MoHealth Net

DURABLE MEDICAL EQUIPMENT MANUAL

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Introduction

The MO HealthNet Durable Medical Equipment (DME) Program provides for payment of certain prescribed DME items for eligible MO HealthNet participants. These items include, but are not limited to, the following: apnea monitors, artificial larynx and related items, augmentative communication devices, canes, crutches, commodes, bed pans, adult incontinence briefs, urinals, Continuous Positive Airway Pressure (CPAP) devices, decubitus care equipment, hospital beds, side rails; humidifiers, Bi-level Positive Airway Pressure (BiPAP) machines, Intermittent Positive Pressure Breathing (IPPB) machines, insulin pumps and supplies, labor and repair codes, nebulizers, orthotics, ostomy supplies, oxygen and respiratory equipment, patient lifts and trapeze, prosthetics, scooters, suction pumps, total parenteral nutrition mix, wheelchairs, wheelchair accessories and walkers.

Section 1: Reimbursement Methodology

1.1 The Basis for Establishing a Rate of Payment

The MO HealthNet Division (MHD) is charged with establishing and administering the rate of payment for those medical services covered by the MO HealthNet Program. MHD establishes a rate of payment that meets the following goals:

- Ensures access to quality medical care for all participants by encouraging a sufficient number of providers
- Allows for no adverse impact on private-pay patients
- Assures a reasonable rate to protect the interests of the taxpayers
- Provides incentives that encourage efficiency on the part of medical providers

Funds used to reimburse providers for services rendered to eligible participants are received in part from federal funds and supplemented by state funds to cover the costs. The amount of funding by the federal government is based on a percentage of the allowable expenditures. The percentage varies from program to program and in some cases different percentages for some services within the same program may apply. Funding from the federal government may be as little as 60% or as much as 90%; depending on the service and/or program. The balance of the allowable, (10-40%) is paid from state General Revenue appropriated funds.

Under a **Fee Schedule**, each procedure, service, medical supply and equipment covered under a specific program has a maximum allowable fee established. MHD determines a maximum allowable fee for the service based upon the current appropriated funds and the following information:

- Recommendations from the state medical consultant and/or the provider subcommittee of the Medical Advisory Committee and/or stakeholders
- Medicare's allowable reasonable and customary charge payment of cost-related payment
- Charge information obtained from providers in different areas of the state. Charges refer to the usual and customary fees for various services that are charged to the general public.

> Implicit in the use of charges as the basis for fees is the objective that charges for service be related to the cost of providing the services.

Total expenditures for MHD must be within the appropriation limits established by the General Assembly. If the expenditures do not stay within the appropriation limits set by the General Assembly and funds are insufficient to pay the full amount, then the payment for services may be reduced pro rata in proportion to the deficiency.

1.2 Durable Medical Equipment Services

Reimbursement for Durable Medical Equipment (DME) services is made on a fee for service (FFS) basis. The maximum allowable fee for a unit of service has been determined by MHD to be a reasonable fee, consistent with efficiency, economy and quality of care. Payment for covered services is the lower of the provider's actual billed charge (should be the provider's usual and customary charge to the general public for the service) or the maximum allowable per unit of service.

A written prescription is required for DME supplies and equipment.

1.3 On-Line Fee Schedule

The **Fee Schedule** identifies covered and non-covered procedure codes, restrictions, allowed units and the allowable fee per unit. The **Fee Schedule** is updated quarterly and is intended as a reference, not a guarantee for payment.

The **Fee Schedule** allows for the downloading of individual files or the search for a specific fee schedule. Some procedure codes may be billed by multiple provider types. Categories within the **Fee Schedule** are set up by the service rendered and are not necessarily provider specific.

Refer to **Section 2** of this manual for program specific benefits and limitations.

1.4 MO HealthNet Managed Care Program

One method in which MHD provides services is through a MO HealthNet Managed Health Care Program. A basic package of services is offered to the participant by the health plan; however, some services are not included and are covered by MHD on a FFS basis.

DME services are included as a plan benefit in the MO HealthNet Managed Care Program.

Managed Health Care

Under a Managed Health Care Plan, a basic set of services is provided either directly or through subcontractors. Managed Health Care Plans are reimbursed at an established rate per member per month. Reimbursement is based on predicted need for health care and is paid for each participant for each month of coverage.

Rather than setting a reimbursement rate for each unit of service, the total reimbursement for all enrollees for the month must provide for all needed health care to all participants in the group covered.

The health plan is at risk for staying within the overall budget—that is, within the negotiated rate per member per month multiplied by the number of participants covered. Some individual cases exceed the negotiated rate per member per month, while many cases cost less than the negotiated rate.

Refer to Section 9 of the General Sections Manual for a detailed description.

Section 2: Benefits and Limitations

2.1 Conditions of Participation

Provider Participation

To participate in the MO HealthNet Durable Medical Equipment (DME) Program, only the following types of providers are reimbursed by MHD for items covered under the DME Program. Each of the following provider types must be enrolled as a DME provider in order to provide DME services:

- Rental and Sales Providers
- Prosthetic Fabricators
- Rehabilitation Centers
- Orthotic Fabricators
- Physicians (M.D., D.O., Podiatrists) (may dispense orthotic devices and artificial larynx)
- Pharmacies
- Hospitals

The following providers may write a prescription for items covered under the DME Program:

- Physicians (M.D., D.O., Podiatrists)
- Advanced Practice Nurses who have a collaborative practice agreement with a physician that allows for prescription of such items

Providers must be Medicare approved prior to enrollment with MHD. Providers must enroll with the same name and address in which their Medicare number is issued. Each Medicare DME supplier must have a separate Medicare number and National Provider Identifier (NPI) for each location. Each location where MHD services are provided must enroll separately. MHD will not backdate enrollment prior to the Medicare effective date. Representatives of a DME company or warehouse are not considered providers and are not eligible to enroll.

Providers submitting claims for DME are required to include the Ordering, Prescribing or Referring (OPR) provider's NPI on the claim. The OPR must be actively enrolled with MHD even if the provider does not accept MO HealthNet participants. If claims are submitted without the enrolled OPR provider's NPI or if the OPR provider is not enrolled with MHD, the claim will be denied.

Additional information on provider conditions of participation can be found in Section 2 of the General Sections Manual.

Face-To-Face Requirements

The Centers for Medicare and Medicaid Services (CMS) revised federal regulation at **42 CFR 440.70** to require that no Medicaid payment for certain items of DME for which Medicare requires a face-to-face encounter shall be made unless there is documentation of a face-to-face encounter that meets all of the following criteria:

- Related to the primary reason the beneficiary requires medical equipment
- Occurs no more than six (6) months prior to the written order
- Occurs prior to the date of service delivery
- Conducted by a physician (M.D. or D.O.) or one of the following non-physician practitioners (NPP):
    - A nurse practitioner working in collaboration with a physician
    - A clinical nurse specialist working in collaboration with a physician
    - A physician assistant, under the supervision of a physician

If an allowed NPP performs the face-to-face encounter, the clinical findings of that face-to-face encounter must be communicated to the enrolled ordering physician and be incorporated into the ordering physician's medical record for the participant.

As indicated in **42 CFR 440.70(g)(1)**, the DME that requires the face-to-face encounter is the same as the DME that requires a face-to-face encounter under the Medicare Program. A list of those items and corresponding Healthcare Common Procedure Coding System HCPCS codes can be found **here**.

Face-To-Face Documentation Requirements

The physician responsible for ordering the DME service must document the face-to-face encounter which is related to the primary reason the patient requires DME. The DME provider must ensure that it has received this documentation for each participant for whom it is required. The DME provider must maintain the documentation in the participant's record or files at their own location.

The documentation must, at a minimum, include all of the following:

- Clinical findings of the face-to-face encounter substantiating the need for the DME
- Primary reason that the DME is required

- Name, signature and credentials of the practitioner who conducted the face-to-face encounter; electronic signatures must meet requirements of electronic signatures for MHD Program, in accordance with **13 CSR 65-3.050**
- Date of the face-to-face encounter

Out-of-State Services

Out-of-state (non-bordering) providers who render services to MHD participants located in Missouri are ONLY permitted to receive reimbursement if:

- Medicare coinsurance and/or deductible amounts on covered services are provided to participants who have BOTH MHD and Medicare.
- DME or supplies are not available in Missouri or a bordering state of Missouri.

If prior authorization (PA) is approved or reimbursement made for a DME item(s) on behalf of an MHD participant who is not Medicare eligible, or for equipment and/or supplies that are available in Missouri or a bordering state, the reimbursement that was paid may be recouped.

2.2 Participant Non-liability

MHD covered services rendered to an eligible participant are not billable to the participant if MHD would have paid had the provider followed the proper policies and procedures for obtaining payment through the MHD Program as set forth in **13 CSR 70-4.030**.

2.3 Emergency Services

Emergency medical/behavioral health services means covered inpatient and outpatient services that are furnished by a qualified provider to evaluate or stabilize an emergency medical condition.

Emergency medical conditions for MO HealthNet Managed Care Health Plan members means medical or behavioral health conditions manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following:

- Placing the physical or behavioral health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment of bodily functions
- Serious dysfunction of any bodily organ or part
- Serious harm to self or others due to an alcohol or drug abuse emergency
- Injury to self or bodily harm to others
- With respect to a pregnant woman having contractions:
    - There is no adequate time to affect a safe transfer to another hospital before delivery;

- That transfer may pose a threat to the health or safety of the woman or the unborn child.

Post stabilization care services mean covered services, related to an emergency medical condition that are provided after a participant is stabilized in order to maintain the stabilized condition or to improve or resolve the participant's condition.

2.4 General Information

The MO HealthNet Program reimburses qualified participating DME providers for certain DME items, such as: prosthetics; orthotics; respiratory care equipment; parenteral nutrition; ostomy supplies; wheelchairs and hospital beds, etc. These items must be ordered in writing by the participant's physician, advanced practice nurse, or nurse practitioner and be suitable for use in any setting in which normal life activities take place, as defined in **42 CFR 440.70(c)(1)**. Nothing shall prevent services from being provided in any setting in which normal life activities take place, other than a hospital, nursing facility; intermediate care facility for individuals with intellectual disabilities; or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

Although an item is classified as DME, it may not be covered in every instance. Coverage is based on the fact that the item is reasonable and necessary for treatment of a disability, an illness or injury, or to improve the functioning of a malformed or permanently inoperative body part and the equipment meets the definition of DME or prosthesis.

Even though a DME item may serve some useful medical purpose, consideration must be given by the physician and the DME supplier to what extent, if any, it is reasonable for MHD to pay for the item as opposed to another realistically feasible alternative pattern of care.

Consideration should also be given by the physician and the DME provider as to whether the item serves essentially the same purpose as equipment already available to the participant.

If two (2) different items each meet the need of the participant, the less expensive item must be employed, all other conditions being equal. Equipment features of an aesthetic or medical nature, which are not medically necessary, are not reimbursable.

MHD is designed to assist participants in obtaining medical care. Reimbursement may be made for expenses incurred for DME services provided the conditions in the following subsections are met.

Durable Medical Equipment

DME is equipment that:

- Can withstand repeated use
- Can be reusable or removable

- Is primarily and customarily used to serve a medical purpose
- Is not useful to a person in the absence of a disability, an illness or injury
- Is appropriate for use in any setting in which normal life activities take place as defined in **42 CFR 440.70(c)(1)**, which specifies that nothing shall prevent services from being provided in any setting in which normal life activities take place, other than a hospital, nursing facility; intermediate care facility for individuals with intellectual disabilities; or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

All requirements must be met in order for the equipment to be covered by MHD.

2.5 Purchase of Durable Medical Equipment

The participant must be eligible for MHD at the time the equipment or device is delivered or obtained with exception to custom-made items. If a custom-made item is ordered, fitted or fabricated when the patient is eligible and they lose eligibility or dies prior to the dispense date, MHD will reimburse that claim. See **Section 2.12** for additional information. Items purchased become the property of the participant.

Some items are covered by MHD as purchase items only, while others are rental items only. Refer to **Section 5** to determine if the item to be dispensed can be purchased or rented.

Purchase of Used Durable Medical Equipment

Used equipment is covered only if the item has been solely used by the participant; i.e. the participant previously rented the equipment.

Delivery of Items Covered Under the Durable Medical Equipment Program

Items that are covered under the DME Program must be dispensed to the participant before the provider bills MHD for the item. Holding equipment until MHD payment is received constitutes a payment for a service not provided and is in violation of **13 CSR 70-3.030 (23)**.

All charges for delivery, pickup, shipping, freight, cash on delivery (C.O.D.) and handling are included in the MHD allowed reimbursement amount and are not paid for separately or billable to the participant.

Replacement of Purchased Items

Replacement of purchased items covered under the DME Program that are medically necessary and are lost, stolen, destroyed or required because of a change in the participant's condition are covered. Items with restriction of pre-certification must contact the MHD call center.

The call center is available Monday through Friday from 8:00 a.m. to 5:00 p.m., excluding state holidays. Items requiring a **PA Request** or **Certificate of Medical Necessity (CMN)** must contain all of the following information:

- Explanation for continuing need of the item
- How the item was lost or destroyed
- Copy of the police report if the item was stolen or destroyed in an automobile accident, fire, etc.
- Nature of the change in the participant's condition

Replacement of items resulting from participant abuse or neglect is not covered and may be billed to the participant.

2.6 Rental of Durable Medical Equipment

The **CMN** attachment or **PA Request** for equipment are reviewed in order to determine initially if the item should be purchased or rented based on the diagnosis and prognosis of the participant and the anticipated period of need prescribed by the participant's physician. Items requiring pre-certification utilize CyberAccess℠, a management tool to determine medical necessity. If the period of need indicates that it is less expensive to purchase the equipment, MHD may elect to purchase the equipment. Likewise, if it is less expensive to rent the equipment, MHD may elect to rent the equipment. If necessary, the routing modifier or service modifier on the PA Request is changed by the consultant. An explanatory message appears on the disposition letter. Providers must request the purchase or rental of equipment based on the anticipated period of need.

Eligibility During Durable Medical Equipment Rental

If a participant is not eligible for MHD covered services during a portion of the rental month, rental is paid only for the days each month the participant is eligible. A message appears on the Remittance Advice (RA) that reflects the reason for the reduced payment. The participant is responsible for the non-eligible rental period.

Reaching the Purchase Price of a Durable Medical Equipment Item

When the rental payments reach the MHD allowed purchase price, the item becomes the property of the participant. A message appears on the RA stating that the equipment has been purchased by MHD and is the property of the participant.

Replacement of Rented Durable Medical Equipment Items

MHD does not reimburse the provider or the participant for the replacement of a rented DME item that is stolen, lost or destroyed.

Billing Guidelines for Durable Medical Equipment Rental

When billing for the rental of a DME item, the "from" and "to" dates of the claim must always be completed. The units of service should always be "1" unless otherwise specified in **Section 5** of this manual.

Once the **CMN**, **PA Request** or pre-certification has been submitted and approved, any claim submitted matching the information on the approved **CMN**, PA or pre-certification can be processed for payment. This includes all monthly claims for rental.

2.7 Repair of Durable Medical Equipment

Repair of participant-owned DME or prosthetic or orthotic device (whether purchased by MHD outright, purchased through rental payments or paid for by the participant) is covered if:

- The item to be repaired is a covered item under the DME Program.
- The repairs do not exceed 60% of the cost of a new piece of equipment or orthotic or prosthetic device. The repair must be calculated at the allowed amount and excludes routine replacement items such as batteries, arm pads, tires, etc. Previously billed repairs cannot be added to the calculation but can be documented to support the need to upgrade equipment to prevent higher costs to the DME program.
- The item is not under the provider's or manufacturer's warranty.
- The repairs are not required as a result of participant abuse.
- The participant is not in an institution unless the repair is for a custom or power wheelchair, augmentative communication device (ACD), orthotic or prosthetic device.
- The equipment is not being rented.
- There is a continuing medical need for the equipment.
- The repairs are not a result of a defect in materials or workmanship.

Reimbursement for a repair is based on the reasonable charge for parts and the allowable reimbursement amount for labor.

Billing Guidelines for Durable Medical Equipment Repair

The HCPCS code for the specific item along with the routing modifier, RB, must be used to bill when submitting a claim for repair of an item. If there is not a specific HCPCS code to use to bill the repair, the following repair codes may be used to bill for pieces and parts:

Procedure Code	Description
Z0160	Repair of equipment, replace or repair minor parts
L4210	Orthotic repair or replace minor parts
L7510	Prosthetic repair or replace minor parts

The amount of time required for the repair or modification may be billed under the following labor codes:

Procedure Code	Description
K0739	Repair or non-routine service for DME, other than oxygen equipment, requiring the skill of a technician, labor component, per 15 minutes
L4205	Repair of orthotic device, labor component, per 15 minutes
L7520	Repair of prosthetic device, labor component, per 15 minutes

List the actual time in the unit's field of the claim form in 15 minute increments.

A **CMN** is required for most repair claims (refer to **Section 5** for specific requirements). The **CMN** information may be submitted through **eMOMED**.

Repairs under $500.00 do not require a physician's signature. The **CMN** must be maintained in the participant's file. The $500.00 includes the price of all items on the claim.

A detailed description and the age of the item being repaired must be documented on the **CMN**. If there is labor to be billed, a detailed explanation of the time involved must also be listed on the **CMN**.

When billing for a repair, copies of the invoices showing the Manufacturer's Suggested Retail Price (MSRP), or the Invoice of Cost (IOC), must be submitted with the claim form through **eMOMED**. Claims are manually priced at this time, not at the time of the approval of the **CMN**.

If a repair requires a PA, a detailed description and the age of the item being repaired must be documented on the PA. If the item(s) requested are manually priced, the IOC or MSRP must be submitted with the PA to establish an allowed amount for reimbursement.

2.8 Warranties

When an orthotic device, prosthetic device or other equipment has been purchased, the following warranties must be provided by the provider, unless the manufacturer's warranty is for a greater length of time. If the manufacturer's warranty is less than the following, a statement from the manufacturer or copy of their printed policy must be submitted.

- One (1) year for prosthetic devices
- Ninety (90) days for custom orthotics
- Thirty (30) days for standard braces
- One (1) year for equipment such as walkers, wheelchairs, hospital beds, etc.

2.9 Trade-In of Durable Medical Equipment

When a DME item is traded in on a new item, the trade-in amount must be deducted from the purchase price and the reduced amount billed. An explanation must be noted on the **CMN** or **PA Request**.

2.10 Reimbursement Guidelines

Manually Priced Items

All items that require manual pricing, with the exception of wheelchairs and accessories, gait trainers, standers and ACDs, are reimbursed based on the actual IOC, of the supply or equipment plus 20%. The actual IOC is submitted with the claims. Items that require manual pricing may be found in Section 5 of this manual.

- Wheelchair and accessories, gait trainers, standers and ACDs are priced based on the MSRP as follows:
- MWC and accessories - 90% of MSRP
- PWC and accessories - 95% of MSRP
- Gait Trainers - 90% of MSRP
- Standers - 90% of MSRP
- ACD - 85% of MSRP

Additional Reimbursement Guidelines

- MHD payment is the lower of the provider's usual and customary charge to the general public or the MHD maximum allowable amount, less any third party resource.
- Sales tax is not covered by MHD, nor can it be billed to the participant. Providers should contact the Tax Administration Bureau on a regular basis to ensure that items covered under the DME Program are not subject to Missouri sales tax.
- Providers may not request or accept a deposit from an MHD participant and then refund it after payment is received from MHD. Accepting a deposit or portion of payment for services from a participant will only be allowed as outlined in **13 CSR 70-4.040** and **13 CSR 70-4.050**.
- Providers must accept the MHD payment as the full and complete payment and may not accept additional payment from the participant. Accepting a portion of payment for services from the participant is in violation of **13 CSR 70-3.030**.
- Quantities in excess of the limit may be covered if medically necessary. Pre-certification of excess quantities must be obtained for items that require pre-certification. For items that do not require pre-certification, medical necessity justification in letter form from the prescriber must be submitted along with a paper claim for review by the MHD state consultant.

- Charges for shipping, freight, C.O.D., handling, delivery and pickup are included in the reimbursement for items covered under the DME Program and are not separately billable to the MHD participant.

2.11 Delivery Requirements

Proof of Delivery

Proof of delivery is required for verification that equipment or supplies were received by the participant. DME providers must maintain proof of delivery documentation in their files for five (5) years for every item provided.

For the purpose of the proof of delivery information provided below, "designee" is defined as "any person who can sign and accept the delivery of DME on behalf of the participant." DME providers, their employees or anyone who may have a financial interest in the delivery of the item are prohibited from signing and accepting an item on behalf of the participant (i.e., acting as a designee on behalf of the participant).

DME providers shall not bill for an item prior to receipt of documentation of proof of delivery. In addition, for DME items that require fitting, set-up and/or instruction, the DME provider shall not bill prior to providing the participant with proper set-up, fitting and instruction. Documentation of any set-up fitting and/or instructions provided must be maintained in the DME provider's participant record.

Direct Delivery

DME providers may deliver an item or supply directly to the participant or their designee. An example of proof of delivery made directly to a participant is a signed and dated delivery slip. It is recommended the delivery slip include the following:

- Participant's name
- Quantity delivered
- Detailed description of the item being delivered
- Brand name of the item
- Serial number (if applicable)

The date of signature on the delivery slip must be the date that the item/supply was received by the participant or designee. In instances where the item/supply is delivered directly by the DME provider, the actual date the participant received the item/supply shall be the date of service on the claim.

Mail Order/Shipping Service Delivery

If a DME provider uses a shipping or mail order service, an example of proof of delivery should include the services tracking slip and the DME provider's own shipping invoice.

If possible, the DME provider's record should also include the delivery service's package identification number for the package sent to the participant. The shipping service's tracking slip should reference each individual package, the delivery address, the corresponding package identification number given by the shipping service and, if possible, the date delivered. DME providers should use the shipping date as the date of service on the claim.

Supply Refills - No Auto Refills

For DME items supplied as refills to the original order (e.g. nebulizers supplies, Continuous Positive Airway Pressure (CPAP) supplies, diapers, etc.), the DME provider must contact the participant or caregiver prior to dispensing the refill and not automatically ship on a pre-determined basis, even if authorized by the participant. This shall be done to ensure that the refilled item remains reasonable and necessary, existing supplies are approaching exhaustion and to confirm any changes/modification to the order. Contact with the participant or designee regarding refills must take place no sooner than 14 days prior to the delivery/shipping date.

For all items provided on a recurring basis, DME providers are required to have contact with the participant or caregiver/designee prior to dispensing a new supply of items. DME providers must not deliver refills without a specific refill request from a participant. Items delivered without a valid, documented refill request are not covered and may not be billed to the participant. For items that the participant obtains in-person at a retail store, the signed delivery slip or a copy of the itemized sales receipt is sufficient documentation of request for refill.

DME providers must not dispense a quantity of supplies exceeding a participant's expected utilization. DME providers must be attentive to changed or atypical utilization patterns on the part of their clients. DME providers must verify with the ordering physicians that any changed or atypical utilization is warranted.

The date of service for items supplied as refills to the original order may be the actual delivery date or ship date depending on the method of delivery, or within three calendar days after the delivery date or ship date. For example, if an item is delivered by the supplier on June 1st, the date of service billed on the claim may be June 1, June 2, June 3 or June 4.

This flexibility is allowed to ensure a participant is able to receive the refill of supplies without a gap in service and the provider is able to bill for the supplies provided.

Exceptions to the Date of Service

A DME provider may deliver a DME item to a participant in a hospital or nursing facility for the purpose of fitting or training the participant in the proper use of them. This may be done up to two (2) days prior to the participant's anticipated discharge to their home.

The DME provider shall bill the date of discharge as the date of service on the claim and use the place of service (POS) 12 (home). No billing may be made for the item for those days the participant was receiving training or fitting in the hospital or nursing facility. The DME provider must ensure the participant's equipment is properly set-up and the patient is instructed on proper use of the equipment prior to billing. Services cannot be billed prior to the date the patient is discharged.

2.12 Payment for Custom-Made Items When Delivery or Placement Cannot be Made Prior to Participant's Loss of Eligibility or Death

MHD payment may be made for custom-made items such as orthotics, prosthetics, custom wheelchairs and custom Healthy Children and Youth (HCY) equipment when the participant becomes ineligible (either through complete loss of MO HealthNet eligibility or change of assistance category to one for which the particular service is not covered) or dies after the item is ordered or fabricated and prior to the date of delivery or placement of the item.

Prerequisite for Payment of Custom-Made Items

The following prerequisites apply to all such payments:

- The participant must have been eligible when the service was first initiated (and following receipt of an approved **PA Request**, if required) and at the time of any subsequent service, preparatory and prior to the actual ordering of fabrication of the device or item.
- The custom-made device or item must have been fitted and fabricated to the specific medical needs of the user in such a manner so as to preclude its use for medical purpose by any other individual.
- The custom-made device or item must have been delivered or placed if the participant is living.
- The provider must have entered "see attachment" in Field #19 of the claim form and must have attached a provider-signed statement to the claim. The statement must explain the circumstances and include the date of actual delivery or placement for a living participant or the date of death when delivery or placement is not possible due to this reason. The statement must also include the total amount of salvage value, which the provider estimate is represented in case where delivery or placement is not possible.

Payment of Custom-Made Items and Devices

The following explains how payment is determined based on the participant's eligibility status:

a. If the item is received by the participant following the loss of MO HealthNet eligibility or eligibility for the service, the payment is the lesser of the "net billed charge" or the MHD maximum allowable amount for the total service, less any applicable cost sharing or copayment.

b. If the item cannot be delivered or placed due to death of the participant, the payment is the lesser of the "net billed charge" or the MHD maximum allowable amount for the total service, less any applicable cost sharing or coinsurance. The "net billed charge" shall be the provider's usual and customary billed charge(s) as reduced by any salvage value amount.

    - "Salvage value" exists whenever there is further profitable use that can be made by the provider of materials or components of the device or item. Dentures are an example of an item representing no reasonable salvage value, whereas a custom-made wheelchair may, in its components, represent salvage value. The salvage value must be clearly documented in the medical records.
    - Any provider-determined retail salvage value of the unplaced or undelivered item must be subtracted by the provider from the charge for the item and only the net-reduced charge entered on the claim form line for the item. These items are subject to review as to salvage value adjustment represented in the billed charge.

c. The date of service that is shown on the claim form for the item (custom wheelchair, braces, etc.) when situation a. or b. applies must be the last date on which service is provided to the eligible participant (and following receipt of an approved PA, if required) prior to the ordering or fabrication of the item. The provider is responsible for verifying participant eligibility each time a service is provided. Use of a date for which the participant is no longer eligible for MO HealthNet coverage of the service results in a denial of the claim. The claim (with attachment) must be submitted to the fiscal agent in the same manner as other claims.

Payments made as described in a. or b. constitutes the allowable MHD payment for the service and no further collection from the participant or other persons is permitted.

If the provider determines the participant has lost eligibility after the service is first initiated and before the custom-made item is actually ordered or fabricated, the participant must be immediately advised that completion of the work and delivery or placement of the item is not covered by MHD. It is then the participant's choice to request completion of the work on a private payment basis. If participant death is the reason for loss of eligibility, the provider can proceed no further and there is no claim for the non-provided item of service.

If a participant refuses to accept the item/service, MHD does not reimburse the provider.

2.13 Managed Care Health Plan

Certain items and/or services that have been initiated or prior authorized by MHD before the enrollment effective date in a Managed Care Health Plan are reimbursed on a fee for service (FFS) basis by the state agency when placement occurs after the Managed Care Health Plan enrollment is effective. MHD FFS is financially responsible for these items or services in accordance with the following:

- ACDs and evaluations, prosthetic and orthotic devices that have been ordered, initiated or prior authorized prior to the enrollment effective date in the Managed Care Health Plan, but placement occurs after the effective date of the Managed Care Health Plan enrollment.
- Custom and power wheelchairs and custom HCY equipment that have been prior authorized by MHD prior to the enrollment effective date in the Managed Care Health Plan, but placement occurs after the effective date of Managed Care Health Plan enrollment.

Providers may contact the Provider Communications Unit at (573) 751-2896 for instructions on how to bill for these items/services.

Certain items and/or services that have been initiated or prior authorized by the Managed Care Health Plan before the effective date enrolled in the MHD's FFS Program are reimbursed by the Managed Care Health Plan when placement occurs after FFS enrollment is effective. The Managed Care Health Plan is financially responsible for these items or services in accordance with the following:

- ACDs and evaluations, prosthetic and orthotic devices that have been ordered, initiated or prior authorized prior to the enrollment effective date in the FFS Program, but placement occurs after the effective date of the FFS Program enrollment.
- Custom and power wheelchairs and custom HCY equipment that have been prior authorized by the Managed Care Health Plan prior to the enrollment effective date in the FFS Program, but placement occurs after the effective date of FFS Program enrollment.

2.14 Coverage of Durable Medical Equipment for Participants in a Nursing Home

DME is not covered for those participants residing in a nursing home (place of service 31 or 99 with level of care 1 or 2). DME is included in the nursing home per diem rate and not paid for separately with the exception of the following items:

- ACDs and Accessories
- Custom Wheelchairs
- Power Wheelchairs
- Orthotic and Prosthetic Devices
- Total Parenteral Nutrition

- Volume Ventilators

MHD requires all providers of custom and power wheelchairs provide equipment that meets the participant's needs for mobility and positioning in a cost-effective manner for participants in a nursing home. The **PA Request** is denied if the chair is considered not medically necessary, if it is not a custom wheelchair or if a less expensive alternative wheelchair is available.

Supporting documentation for custom and power wheelchairs must be included with the PA Request. Section 1, Field #9 of the PA Request form must clearly list the name and address of the nursing home in which the participant resides.

Prior Authorization Request/Letter of Medical Necessity for Custom or Power Wheelchairs

When submitting a **PA Request** for a custom or power wheelchair, there must be comprehensive written documentation submitted with the PA Request. Letters of medical necessity (LMNs) and supporting documentation must be signed by the prescribing physician as well as the nursing home's director of nursing or the nursing home's employed or contracted licensed physical or occupational therapist (the physical or occupational therapist may have no financial relationship with the DME provider, except for hospital-based providers). In addition, LMNs generated by the supplier must be written on the supplier's letterhead and signed by both the supplier and the prescribing physician as well as the nursing home's director of nursing or the nursing home's employed or contracted licensed physical or occupational therapist (the physical or occupational therapist may have no financial relationship with the DME provider, except for hospital-based providers).

LMNs must clearly and specifically explain the following:

- The diagnosis/comorbidities and conditions relating to the need for a custom or power wheelchair.
- Description and history of limitations/functional deficits.
- Description of physical and cognitive abilities to utilize equipment.
- History of previous interventions/past use of mobility devices.
- Description of existing equipment, age and specifically why it is not meeting the participant's needs
- Explanation as to why a less costly mobility device is unable to meet the participant's needs (i.e., cane, walker, manual wheelchair)
- Documentation and justification of medical necessity of recommended mobility device, accessories and positioning components
- Documentation/explanation of participant's ability to safely tolerate/utilize the recommended equipment
- Documentation/explanation as requested by the state consultant

Assistive Technology Professional

Custom or power wheelchairs for participants residing in a nursing home must be supplied by a DME provider that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs. The ATP must have direct, in-person, face-to-face interaction, after the physician or nurse practitioner's face-to-face examination and involvement in the wheelchair selection for the participant. The provider record should document how the ATP was involved and directed the wheelchair selection process.

Physician Face-To-Face Examination

For a custom or power wheelchair to be covered for a participant residing in a nursing home, a treating physician must be the first point of contact with the participant and conduct a face-to-face examination of the participant before writing an order for the custom or power wheelchair. The physician's required face-to-face examination must be completed prior to any evaluation or contact by any person associated with the DME provider, including an ATP. Physicians shall document the face-to-face examination in a detailed narrative note in the participant's chart in the format they use for other entries. Forms or sample documentation created by a supplier or facility that the physician completes are not a substitute for the comprehensive medical record/chart note indicated above. The physician face-to-face examination must provide information about the following elements but may include other details:

History of the present condition(s) and past medical history that is relevant to mobility needs:

- Symptoms that limit ambulation
- Diagnoses that is responsible for symptoms
- Progression of ambulation difficulty over time
- Other diagnoses that may relate to ambulatory problems
- Cardiopulmonary examination
- Weight and height

Physical examination that is relevant to mobility needs:

- Existing ambulatory assistance (cane, walker, wheelchair, caregiver) that is currently being utilized
- Ability to stand up from a seated position without assistance
- Description of the ability to perform activities of daily living
- Distance the participant can walk without stopping
- Pace of ambulation
- Musculoskeletal examination to include arm and leg strength and range of motion
- Neurological examination to include documentation of functional ambulation and balance and coordination
- Weight and height

The physician examination must be tailored to the individual participant's condition. The history must clearly illustrate the participant's functional abilities and limitations on a typical day and contain as much objective data as possible. This should include a description of qualifying diagnosis/criteria such as a severe orthopedic abnormality of the hip, spine or pelvis requiring a customized or power wheelchair. The physical examination must be focused on the body systems responsible for the participant's ambulatory difficulty or impact on the participant's ambulatory ability.

After the face-to-face examination with the physician, the physician may choose to refer the participant to a licensed physical therapist or occupational therapist for completion of the physical portion of the examination. If utilized, the therapy examination must be authorized by the therapist and reviewed by the physician after completion, agreed upon or amended. The therapy evaluation would complete the physical portion of the face–to-face examination and would contain all the required items listed under the physical portion of the face-to-face examination. This would be a therapy evaluation only, not a wheelchair evaluation.

A prior evaluation completed by a licensed physical or occupational therapist within the past 90 days may also be utilized for the physical portion of the examination. All areas noted above for the physical examination must be addressed. If utilized, the physical or occupational therapist examination must be reviewed by the physician after completion, agreed on or amended and signed before issuing the physician order.

The physical or occupational therapist may have no financial relationship with the DME provider, except for hospital-based providers. There is no separate reimbursement outside the nursing home per diem for a physical or occupational therapist evaluation.

The face-to-face examination must be completed by the physician or nurse practitioner prior to any evaluation performed by the DME provider, including the ATP. The DME provider must receive the written report of this examination within 90 days after completion of the face-to-face physician examination. A date stamp or equivalent must be used to document the date that the provider receives the report of the face-to-face physician examination. The written report of the physician examination must be submitted with the PA Request.

Evaluations written or scribed by the DME provider and signed by the therapist is not acceptable as an occupational/physical therapist evaluation. All documentation from the DME provider should be separate from the therapy evaluation. All documentation submitted by the ATP should be on DME letterhead, signed and dated by the ATP.

All documentation explaining medical necessity for items requested on the PA Request must be reviewed and approved by the physician/practitioner as indicated by signing and dating the document.

Physician Order

When requesting a custom or power wheelchair for a nursing home participant, a physician order must be received by the DME provider within 90 days after completion of the face-to-face physician examination and prior to any DME provider evaluation. The physician order must contain all of the following:

- Participant's name
- Description of the item that is ordered (may be general such as power wheelchair, manual wheelchair)
- Date of the face-to-face examination
- Pertinent diagnoses/conditions that relate to the need for the custom or power wheelchair;
- Length of need
- Physician's signature
- Date of physician's signature

A date stamp or equivalent must be used to document receipt date of the physician or nurse practitioner order. This order must be included with the PA Request. If it is not included, the PA Request will be returned as incomplete.

Power Wheelchairs and Accessories for Nursing Home Participants

In addition to the requirements above, requests for Group 2 power wheelchairs (PWC) for nursing home participants must:

A. Document one of the following diagnoses groups:
   - Spinal cord injury resulting in quadriplegia or paraplegia (G82.20, G82.21, G82.22, G82.50, G82.51, G82.52, G82.53, G82.54)
   - Other spinal cord diseases (G32.0, G95.0, G95.11, G95.19, G95.899)
   - Multiple Sclerosis (G35)
   - Other demyelinating disease (G36.0, G36.1, G36.8, G36.9, G37.0, G37.1, G37.2, G37.3, G37.4, G37.5, G37.8, G37.9)
   - Cerebral Palsy (G80.0, G80.1, G80.2, G80.3, G80.4, G80.8, G80.9)
   - Anterior Horn Cell Diseases including Amyotrophic Lateral Sclerosis (G12.0, G12.1, G12.20, G12.21, G12.23, G12.24, G12.25, G12.29, G12.8, G12.9)
   - Post-polio paralysis (B91, G14)
   - Traumatic brain injury resulting in quadriplegia (G82.50)
   - Spina Bifida (Q05.0, Q05.1, Q05.2, Q05.3, Q05.4, Q05.5, Q05.6, Q05.7, Q05.8, Q05.9, Q07.01, Q07.03)
   - Childhood cerebral degeneration (E75.23, E75.25, E75.29, F84.2, G31.9, G93.89, G83.9)
   - Huntington's Disease (G10)

- The participant has had a leg and arm amputation or congenital deformity resulting in non-functional use of 3 or more limbs
- The participant has non-functional paralysis for two or more limbs and permanent non-functional use of a third limb
- Current stage II or greater pressure ulcer (L89) on the area of contact with the seating surface (trunk, spine or pelvis) (must be noted and described by the physician in the face-to-face visit; justification must document what other types of skin protection measures have been utilized)
- Severe orthopedic abnormality of the hip, spine or pelvis significantly affecting positioning (must be documented by the physician in the face-to-face visit)

B. Explain why a less costly mobility device is unable to meet the participant's needs including a description of equipment trials and their effectiveness.

The information must be supported by diagnosis in the patient's file. It must be included in the detailed physician chart note including the documentation of the physical examination portion of the face-to-face encounter. The documentation must accompany the PA Request from the DME provider.

Requests for Group 3 PWC wheelchairs will only be considered when the following criteria are met:

- All criteria for a Group 2 PWC are met
- Medical justification provides extensive documentation of why a Group 2 PWC and other less costly devices will not meet the participant's needs
- Documentation includes the length of time the participant has resided in the nursing home
- One (1) of the following:
    - Documentation includes a copy of the discharge plan from the nursing home's participant record that clearly states the participant's discharge date is in the next 90 days to an independent or less restrictive living environment and that the participant will be involved in activities that require the client to utilize a wheelchair in the community on a frequent basis (e.g. work, shopping, self-transport to appointments). Supporting documentation from a physician, social worker or occupational/physical therapist explaining the participant's discharge plans and mobility needs must accompany the discharge plan.
    - The medical necessity justification provides clear documentation that the participant requires specialty controls other than a joy stick to independently operate the wheelchair.
    - If the patient's weight is greater than 300 pounds and there is no availability of a heavy-duty Group 2 PWC, a less costly Group 3 PWC, with single power, will be considered.

The following equipment is not considered medically necessary for participants residing in a nursing home:

- Group 1 PWC
- Group 4 PWC
- Multiple power seat function (i.e., power tilt and recline)
- Power elevating leg rests/lower extremity power articulating platform

Coverage of Custom Wheelchairs for Nursing Home Participants

MHD will reimburse for medically necessary custom wheelchairs for participants residing in a nursing facility. A custom wheelchair is defined as a chair that is tailor made for one participant and cannot be used by anyone else. PA is required. All **PA Request** must indicate why a less costly wheelchair is unable to meet the participant's needs. Criteria A, B and C below describes the criteria utilized for a wheelchair to be considered custom. Criteria for individual HCPCS codes are listed following criteria A, B and C below.

A. Any wheelchair with a custom seating system. A custom seating system is a wheelchair seating system which is individually made for a patient using a plaster model of a patient, a computer generated model of the patient (i.e. CAD-CAM technology), or the detailed measurements of the patient to create either:
    - A molded, contoured, or carved (foam or other suitable material) custom-fabricated seating system that is incorporated into the wheelchair base
    - A custom seating system made from multiple pre-fabricated components or a combination of custom fabricated materials and pre-fabricated components which have been configured and attached to the wheelchair base or incorporated into a wheelchair seat and/or back in a manner that the wheelchair could not be easily re-adapted for use by another individual.

    To qualify for a custom seating system, an individual must meet all the requirements of a custom fabricated seat cushion or a custom fabricated back cushion as described in Section 2.27 of this manual. The PA Request must document the following:

    - Why a pre-fabricated system is not sufficient to meet the participant's seating and positioning needs;
    - What orthopedic deformity is present and its fixed or flexible presentation
    - What altered muscle tone is present and its increased or decreased presentation that affects seating and positioning
    - Why any existing system is not meeting the participant's seating and positioning needs

B. A specially-sized or constructed wheelchair that is provided to a participant whose anatomical measurements require the following:

- Wheelchair seat width of 25 inches or more
- Wheelchair with a weight capacity for 351 or more pounds
- Wheelchair with a seat to floor height of less than 15 1/2 inches

C. A wheelchair for a participant who has absent or impaired sensation in the area of contact with the seating surface or inability to carry out a functional weight shift due to one of the following diagnoses groups or conditions:

- Spinal cord injury resulting in quadriplegia or paraplegia (G82.20, G82.21, G82.22, G82.50, G82.51, G82.52, G82.53, G82.54)
- Other spinal cord diseases (G320, G95.0, G95.11, G95.19, G95.89, G99.2)
- Multiple sclerosis (G35)
- Other demyelinating disease (G36.0, G36.1, G36.8, G36.9, G37.0, G37.1, G37.2, G37.3, G37.4, G37.5, G37.8, G37.9)
- Cerebral palsy (G80.0, G80.1, G80.2, G80.3, G80.4, G80.8, G80.9)
- Anterior horn cell diseases including amyotrophic lateral sclerosis (G12.0, G12.1, G12.20, G12.21, G12.23, G12.24, G12.25, G12.29, G12.8, G12.9)
- Post-polio paralysis (B91, G14)
- Traumatic brain injury resulting in quadriplegia (G82.50)
- Spina bifida (Q05.0, Q05.1, Q05.2, Q05.3, Q05.4, Q05.5, Q05.6, Q05.7, Q05.8, Q05.9, Q07.01, Q07.03)
- Childhood cerebral degeneration (E75.23, E75.25, E75.29, F84.2, G31.9, G93.89, G93.9)
- Huntington's disease (G10)
- Current stage II or greater pressure ulcer (L89) on the area of contact with the seating surface (trunk, spine or pelvis). Current stage II or greater pressure ulcer must be noted and described by the physician in the face-to-face visit; justification must document what other types of skin protection measures have been utilized.
- Severe orthopedic abnormality of the hip, spine or pelvis significantly affecting positioning. Any or all of these abnormalities must be noted and described by the physician in the documentation of the face-to-face visit.

HCPCS code specific requirements are as follows:

- Wheelchairs described by HCPCS codes K0001, K0002 and K0003 will not be considered custom wheelchairs.
- Wheelchairs described by HCPCS code K0004 may be considered custom if criterion A, B or C above is met. Documentation for K0004 must justify why a less costly device cannot be used.
- Wheelchairs described by HCPCS code K0005 may be considered custom if criterion A or B above is met along with one of the following diagnosis groups:

    - Spinal cord injury resulting in quadriplegia or paraplegia (G82.20, G82.21, G82.22, G82.50, G82.51, G82.52, G82.53, G82.54)
    - Other spinal cord diseases (G32.0, G95.0, G95.11, G95.19, G95.89, G99.2)
    - Multiple Sclerosis (G35)
    - Other demyelinating disease (G36.0, G36.1, G36.8, G36.9, G37.0, G37.1, G37.2, G37.3, G37.4, G37.5, G37.8, G37.9)
    - Cerebral Palsy (G80.0, G80.1, G80.2, G80.3, G80.4, G80.8, G80.)
    - Anterior Horn Cell Diseases including Amyotrophic Lateral Sclerosis (G12.0, G12.1, G12.20, G12.21, G12.23, G12.24, G12.25, G12.29, G12.8, G12.9)
    - Post-polio paralysis (B91, G14)
    - Traumatic brain injury resulting in quadriplegia (G82.50)
    - Spina Bifida (Q05.0, Q05.1, Q05.2, Q05.3, Q05.4, Q05.5, Q05.6, Q05.7, Q05.8, Q05.9, Q07.01, Q07.03)
    - Childhood cerebral degeneration (E75.23, E75.25, E75.29, F84.2, G31.9, G93.89, G93.)
    - Huntington's Disease (G10)
    - Current stage II or greater pressure ulcer (L89) on the area of contact with the seating surface (trunk, spine or pelvis). Current stage II must be noted and described by the physician in the face-to-face visit documentation; justification must document what other types of skin protection measures have been utilized.
    - Severe orthopedic abnormality of the hip, spine or pelvis significantly affecting positioning. Any or all of these abnormalities must be noted and described by the physician in the face-to-face visit documentation.
- Documentation for a K0005 must justify why a K0004 and other less costly device cannot be used.
- Wheelchairs described by HCPCS code E1161 may be considered custom if criterion C above is met.
- Wheelchairs described by HCPCS codes K0006 and K0007 may be considered custom if two (2) of the requirements stated in criterion B above are met.
- Wheelchairs described by HCPCS code K0009 will generally be considered noncovered for participants residing in a nursing home. Requests for K0009 wheelchairs will only be considered in extenuating circumstances and when the following exists:
    - Extensive documentation explaining why no other manual wheelchair (K0001-K0007) will meet the participant's needs.
    - The participant's anatomical measurements are provided and document the participant requires one of the following:
        - A wheelchair seat width of 25 inches or more
        - A wheelchair with a weight capacity of 351 or more pounds

Wheelchairs and Options/Accessories for Nursing Home Participants

MHD requires use of the item-specific HCPCS code for all wheelchairs and wheelchair option/accessories for nursing home participants. The modifier SC must be added to the HCPCS code along with the appropriate NU (purchase) or RR (rental) modifier.

All wheelchair bases, initial options/accessories and upgrade options/accessories for participants residing in a nursing home require PA.

PLEASE NOTE: MHD reimbursement for wheelchairs and wheelchair options/accessories for participants residing in a nursing home is limited to participant-owned custom or power wheelchairs. Custom wheelchairs must meet the definition of a custom wheelchair. Reimbursement for all other manual wheelchairs and options/accessories is included in the nursing home per diem.

Dual Eligible (Medicare & MO HealthNet) Participants

Claims for wheelchair bases, accessories and repairs for nursing home participants who have Medicare Part A and/or B and the stay is not covered by Medicare, do not require a Medicare denial with the claim.

Providers are required to bill the Medicare Part C plan for wheelchair bases, accessories and repairs when a participant is residing in a nursing facility.

2.15 Coverage of Durable Medical Equipment for Participants in a Hospital

DME items dispensed to a participant while receiving inpatient or outpatient care is included in the hospital payment and not paid for separately under the DME Program.

A hospital enrolled as a DME provider cannot be paid through the DME Program for any item covered under the DME Program that is used for inpatient/outpatient care.

2.16 Augmentative Communication Devices

Augmentative Communication Device Definition

ACDs are speech prostheses and are considered DME. ACDs are alternative and supplemental communication equipment used to overcome or ameliorate an individual's inability to communicate due to a disease or medical condition that precludes or significantly interferes with the participant's participation in activities of daily living. Examples of ACDs are communication picture boards/books, speech amplifiers, speech enhancers and electronic devices that produce speech or written output. Related accessories such as overlays, batteries, wheelchair mounts, switches, cables, pointing devices, etc. are also considered. A portable or desktop computer is only considered when the primary use of the computer is the participant's communication device.

Examples of noncovered items include, but are not limited to: printers, office/business software, software intended for academic purposes, Internet access and computer tables.

Eligibility for Augmentative Communication Equipment

MHD reimburses for electronic or manual ACDs, regardless of the participant's age, when the device is deemed medically necessary through pre-certification. DME pre-certification criteria documents may be found on **MHD's website**. Refer to **Section 2.30** for pre-certification guidelines.

The MSRP is required for manually-priced procedure codes. Refer to **Section 5** for specific procedure code restrictions. The MSRP should be submitted electronically with the claim. The attachment and completion of the MSRP instructions are available on **eMOMED**.

Augmentative Communication Device Evaluation Team/Site

For an ACD team/site currently enrolled as a speech-language pathologist, rehabilitation center or outpatient hospital that wishes to be considered as an MHD ACD evaluation team/site, please contact the Missouri Medicaid Audit and Compliance (MMAC), Provider Enrollment Unit, via e-mail at: **MMAC.Provider Enrollment@dss.mo.gov**. Providers should state if they are currently enrolled as an MHD provider. Approval is given to speech-language pathologists, rehabilitation centers or outpatient hospitals that meet the following criteria:

- The ACD team/site leader must be a Missouri licensed speech-language pathologist who has a certificate of clinical competency from the American Speech-Language-Hearing Association.
- The speech-language pathologist must possess at a minimum two (2) years experience in the evaluation and selection of ACDs and must have expertise in the determination of which speech and specific ACD and strategies to use to maximize functional communication.
- In addition to the speech-language pathologist, team membership may include, but is not limited to the following: Missouri licensed audiologist, educator, occupational therapist, physical therapist, physician, manufacturer's representative, social worker, case manager or a second speech pathologist. At least two (2) of these professionals must participate in the ACD evaluation. ACD team/site membership may change with each evaluation performed.
- The speech pathologist or any of the ACD team members may not be a vendor of ACDs or have a financial relationship with a vendor/manufacturer. This excludes the manufacturer's representative.

A description of the ACD team/site evaluation protocol as well as equipment available for an ACD evaluation must be submitted to MMACProvider Enrollment Unit.

Approval is granted based on an ACD team evaluation concept and compliance with the requirements. The provider is notified in writing of any deficiencies. Approval may be granted upon correction of these deficiencies.

Augmentative Communication Evaluation for Augmentative Communication Devices

The ACD evaluation must be performed by an MHD approved ACD evaluation site. The ACD evaluation must be documented in the participant file and must include the following information:

- Medical diagnosis related to communication dysfunction leading to the need for an ACD
- Current communication status and limitations
- Speech and language skills, which must include prognosis for speech and/or written communication
- Cognitive readiness for use of an ACD
- Interactional/behavioral and social abilities both verbal and nonverbal
- Cognitive, postural, mobility, sensory (visual and auditory), capabilities and medical status
- Limitations of participant's current communication abilities without an ACD (if a device is currently in use, a description of the limitation of this device)
- Motivation to communication via use of an ACD
- Residential, vocational, educational and other situations requiring communication;
- Participant's name, address, date of birth and MO HealthNet ID number
- ACD's ability to meet projected communication needs (e.g., ACD growth potential, how long it meets needs)
- Anticipated changes, modification or upgrades for up to two (2) years
- Training plans
- Plans for parental/caregiver training and support
- Statement as to why prescribed ACD is the most appropriate and cost effective device. Comparison of the advantages, limitations and cost of alternative systems evaluated with the participant must be included
- Complete description of ACD prescribed including all medically necessary accessories or modification

Modification/Replacement/Repair of an Augmentative Communication Device

The initial prescription for an ACD should attempt to take into account all projected changes in a participant's communication abilities for at least two (2) years. However, if changes occur in participant needs, capabilities or potential for communication, necessary modifications/replacements may be considered.

Supporting documentation for the modification or replacement must include:

- Reevaluation of the participant by an MHD approved ACD evaluation team/site
- Changes in the participant's communication abilities that support the medical necessity/appropriateness of the requested changes

If requesting a different ACD from the one currently in use by the participant, a new ACD evaluation by an MHD approved site must be performed. Pre-certification is required.

Replacement of an ACD is considered due to loss, non-repairable damage, or if the ACD is no longer functional. Pre-certification is required.

Routine repairs of an ACD not covered by warranty, are covered. A **CMN** must be submitted and must document the reason for the repair. The participant's physician must sign the **CMN** if the total cost of the repair is $500.00 and over. Battery replacement is considered a repair.

Rental of an Augmentative Communication Device

Rental of an ACD is approved only if the participant's ACD is being repaired, modified or if the participant is undergoing a limited trial period (three (3) months) to determine appropriateness and ability to use the ACD. If a trial period (three (3) months) is recommended, the trial period and the subsequent purchase of an ACD require separate pre-certification. The treating speech-language pathologist must confirm the participant is utilizing the selected device daily and accurately in a variety of communication situations and demonstrates the cognitive and physical ability to effectively use the device during the trial period.

In addition to the modifier NU, new equipment, modifier NR, new when rented, will be assigned with the approved pre-certification for the purchase following the required trial period of an ACD. The DME provider must submit the appropriate procedure code with both NU and NR modifiers when billing the purchase of the device.

All rental payments are deducted from the MHD purchase price should the trial period indicate the need for purchase of the device. The combined reimbursement for each month of the trial period (three (3) months) and subsequent purchase is complete payment for the device.

2.17 Equipment

Canes, crutches, walkers, commodes, decubitus care equipment, hospital beds, bed side rails, bed pans, trapeze equipment, etc. are covered equipment. For specific equipment codes and billing requirements, refer to **Section 5** of this manual.

Manual Hospital Beds

Manual hospital beds are reimbursed on a rent-to-purchase basis only and require pre-certification thru the CyberAccess℠ web portal. DME pre-certification criteria documents may be found on **MHD's website**. Refer to **Section 2.30** for pre-certification guidelines.

Semi-Electric Hospital Bed

Semi-electric hospital beds are reimbursed on a rent-to-purchase basis only and require pre-certification. DME pre-certification criteria documents may be found on **MHD's website**. Refer to **Section 2.30** for pre-certification guidelines.

Trapeze Bar

A trapeze bar is covered when the participant is bed confined and the device is needed to change body positioning or to get in and out of bed due to respiratory conditions or other medical reasons.

Mattress and Side Rails

A mattress and/or side rails cannot be billed in addition to a hospital bed. Mattress and side rails may only be billed when the bed is owned by the participant or if needed for replacement.

Side rails may be covered if the participant is bed confined, disoriented, experiences vertigo, has a neurological disorder, or is paraplegic or quadriplegic.

Canes and Crutches

Canes and crutches require pre-certification. DME pre-certification criteria documents may be found on **MHD's website**. Refer to **Section 2.30** for pre-certification guidelines.

Walkers

Walkers require pre-certification. DME pre-certification criteria documents may be found on **MHD's website**. Rollator walkers are a non-covered item.

Commodes

Commodes require pre-certification and are purchase items only. DME pre-certification criteria documents may be found on **MHD's website**. Refer to **Section 2.30** for pre-certification guidelines.

Patient Lift (Hydraulic)

Hydraulic patient lifts are reimbursed on a rent-to-purchase basis only and require pre-certification. DME pre-certification criteria documents may be found on **MHD's website**. Refer to **Section 2.30** for pre-certification guidelines.

Electric lifts are not covered.

Pressure Reducing Support Surfaces

Pressure reducing support surfaces, other than those listed below, require pre-certification. DME pre-certification criteria documents may be found on **MHD's website**. Refer to **Section 2.30** for pre-certification guidelines.

Pressure reducing support surfaces such as a powered air flotation bed (low air loss therapy—E0193), powered pressure reducing mattresses, or air fluidized beds (E0194) are not covered under the HCY or DME Programs. These types of pressure reducing support surfaces may be requested through the Exceptions Program. Refer to the Exceptions Manual for requirements regarding consideration of coverage.

Coverage Criteria for Osteogenesis Stimulator, Low Intensity Ultrasound, Non-Invasive (E0760 NU)

Osteogenesis stimulators are covered for those participants who meet the DME pre-certified medical criteria. DME pre-certification criteria documents may be found on **MHD's website**. Refer to **Section 2.30** for pre-certification guidelines.

The provider of the osteogenesis stimulator must assure that the participant utilizing the device is properly instructed in use of the device in support of the ordered treatment and is aware of and understands any emergency procedures regarding the use of the osteogenesis stimulator device. The provider must maintain written documentation in the participant's medical record regarding the instruction of use for the osteogenesis stimulator.

The device must be capable of producing a treatment log indicating the participant's use. This information must be available to MHD upon request.

The device is reimbursed as a -purchase item only and may only be supplied once in a lifetime.

2.18 Healthy Children and Youth Early and Periodic Screening, Diagnostic and Treatment Program (For Participants 20 and Under)

A medically necessary item or service that is normally noncovered that is identified as a result of a physician, or other health care professional, visit or exam (interperiodic screen) may be covered for participants age 20 and under.

It is important to note that every MO HealthNet eligible child should have a complete HCY/EPSDT screen. If the child has not had a full screen, the provider should refer the child for a full screen to be done at a later date.

Refer to **Section 5.1** for reimbursement guidelines, quantity limitations and specific restrictions for each HCY procedure code.

Under Pads, Diapers, Briefs and Protective Underwear/Pull-Ons

Underpads, diapers, briefs and protective underwear/pull-ons require pre-certification. Any combination of incontinence products is limited to 186 per month and will be pre-certified without the EP modifier. Claims submitted for quantities of 186 per month or less should exclude the EP modifier. For quantities exceeding 186 per month, justification of medical necessity must be submitted through a CyberAccess[sm] help ticket or a phone call to the help desk is required and justification of medical necessity may need to be submitted. If approved, pre-certification will include an EP modifier and claims submitted for quantities of greater than 186 per month should include the EP modifier. DME pre-certification criteria documents may be found on **MHD's website**. Refer to **Section 2.30** for complete pre-certification guidelines.

Providers must not dispense any incontinence products unless the participant agrees replacement of the item is desired and necessary; no automatic shipping is allowed.

Rent-To-Purchase for Chest Wall Oscillation Devices (E0483 EP RR)

High frequency chest wall oscillation devices (E0483 EP RR) are only covered for participants age 20 and under and are reimbursed on a rent-to-purchase basis only. If the device continues to be utilized and is medically necessary, it will be considered purchased after the total of all rental payments equals the purchase price. If the use of device is discontinued at any time, the provider must stop billing for the device.

Chest wall oscillation device rental (E0483 E PRR) requires pre-certification. DME pre-certification criteria documents may be found on **MHD's website**. Refer to **Section 2.30** for pre-certification guidelines.

Pulse Oximeter

Pulse Oximeter Reimbursement

Pulse oximeters are reimbursed on a rent-to-purchase basis. Pre-certification is required. DME pre-certification criteria documents may be found on **MHD's website**. Refer to **Section 2.30** for pre-certification guidelines.

Pulse Oximeter Supplies

All oximeters that are rented include probes, cables, repair, education, maintenance and periodic downloading of recorded data, as requested by the participant's physician.

For pulse oximeters that have been purchased, one (1) non-disposable probe per 12-month period or ten (10) disposable probes per one (1)-month period is allowed for participants age 20 and under. A **CMN** justifying the need for the replacement probe must be maintained in the file.

The **CMN** must also justify the use of disposable probes as opposed to non-disposable probes when disposable probes are utilized.

Providers must not dispense supplies based solely on quantity limitations. The participant must agree that replacement of supplies is desired and necessary; no automatic shipping of supplies is allowed. Billing for pulse oximeter probes above the quantity allowed as the usual maximum quantity, in the absence of documentation clearly explaining the medical necessity of the excess quantity, is denied as not medically necessary. A letter of justification from the participant's physician must be submitted with the claim form for probes in excess of those allowed.

Cough Stimulating Device

Cough stimulating devices are covered for participants age 20 and under and are reimbursed on a rent-to-purchase basis only. Pre-certification is required. DME pre-certification criteria documents may be found on **MHD's website**. Refer to **Section 2.30** for pre-certification guidelines.

Cranial Remolding Orthosis

Cranial remolding orthosis, pediatric, rigid with soft interface material (S1040 EP NU) is reimbursed as a purchase item only. A neurosurgeon and/or cranial facial team must prescribe use of the cranial remolding orthosis as an appropriate form of treatment for participants from birth through 12 months of age.

The orthotist providing the cranial orthosis must be trained and certified to evaluate, modify and dispense the cranial orthosis for proper fit. The fabricated cranial orthosis must have FDA 510(K) clearance.

Cranial remolding orthosis require pre-certification. Any replacement of the cranial orthosis due to growth during the post-operative period for the diagnosis of craniosynostosis will require a new pre-certification. DME pre-certification criteria documents may be found on **MHD's website**. Refer to **Section 2.30** for pre-certification guidelines.

2.19 Total Parenteral Nutrition

Total Parenteral Nutrition (TPN) is covered for participants with severe permanent disease of the gastrointestinal tract that prevents absorption of sufficient nutrients to maintain weight and strength.

The participant must have a condition involving the gastrointestinal tract that results in significant malabsorption. TPN is noncovered for conscious participants whose need for parenteral nutrition is due to lack of appetite or a cognitive problem. The participant must require TPN to sustain life. Adequate nutrition must not be possible by dietary adjustment, oral supplements, or tube enteral nutrition.

TPN is covered under the DME Program for participants in a nursing home.

One (1) supply kit (B4220 or B4222) and one (1) administration kit (B4224) is covered for each day that parenteral nutrition is administered, when such kits are used and medically necessary.

When homemix TPN solutions are used the component carbohydrates amino acids, additives and lipids are separately billable.

When premix TPN solutions are used there is no separate authorization for the carbohydrates, amino acids or additives (vitamins, trace elements, heparin, electrolytes). However, lipids may be separately authorized with premix solutions. An IOC is required when billing for B5200.

TPN procedure codes that are defined as one (1) unit equals one (1) day may be billed by date of service or by consecutive dates of service. Participants receiving TPN on Monday, Wednesday and Friday must be billed by date of service while participants with daily infusions should be billed with from and through dates of service. The number of units billed must equal the number of days when billing consecutive from and through dates of service.

TPN procedure codes that are defined as one (1) unit equals 500 ml must be billed as such. These procedure codes should be billed on the date the item is initially dispensed regardless of the number of days it covers. Refer to **Section 5** for TPN procedure codes and restrictions.

Parenteral nutrition infusion pumps, portable or stationary, are reimbursed on a rent-to-purchase basis only. Pumps are considered purchased after the total of rental payments equals the purchase price. Refer to **Section 5** for reimbursement guidelines. If use of the device is discontinued at any time, the provider must discontinue billing of the device.

TPN formula, supplies and infusion pumps require pre-certification. DME pre-certification criteria documents may be found on **MHD's website**. Refer to **Section 2.30** for pre-certification guidelines.

2.20 Enteral Nutrition

MHD covers medically necessary enteral nutrition products for children under the age of 21.

Enteral Nutrition Formula

Enteral nutrition is covered for a patient under the age of 21 when criteria A *OR* B are met *AND* both C and D are met.

A. WIC (Special Supplemental Nutrition program for Women, Infants and Children) eligibility has been ruled out
B. WIC benefit is exhausted (as determined by the Department of Health and Senior Services)
C. WIC eligibility information from A or B above is documented in the DME Provider Record
D. The child also meets *ONE* of the following medical criteria:
    1. Has a nasogastric tube, gastrostomy tube or jejunostomy tube for feeding purposes

2. Is under six (6) years of age and has a diagnosis of failure to thrive (defined as: oral intake less than bodily requirements; an imbalance possibly related to the inability to ingest/digest/absorb nutrients)
3. Meets the criteria below in a AND also meets EITHER criterion b OR c:
    a. Has ONE (1) of the following diagnoses: ALS, cystic fibrosis, esophageal/stomach cancer, pulmonary insufficiency, non-healing/chronic wounds, dysphagia, renal failure (on dialysis), advanced AIDS with gastrointestinal co-morbidity, severe trauma or burns, traumatic brain injury
    b. During the past six (6) weeks has a documented serum protein level below six (6) and/or serum albumin level below 3.5 performed by an accredited lab
    c. Recent dietician evaluation determines sufficient caloric intake is not obtainable through regular food preparation alternatives (i.e. liquefied/pureed foods); or a speech pathologist evaluation documents a failed swallow study
4. Has an unplanned weight loss of 10% or more over the past three (3) months plus at least ONE (1) of the following conditions:
    a. On-going cancer treatment
    b. Advanced AIDS
    c. Pulmonary insufficiency
    d. Status post severe trauma/burn/brain injury
    e. One of the following malabsorption diagnoses: Short bowel syndrome, celiac sprue, tropical sprue, gastrointestinal fistula, nutritional marasmus, Whipple's disease, intestinal lymphangiectasis, chronic carbohydrate intolerance
5. The participant has ONE (1) of the conditions listed in 4 a-e above and a history of body weight maintained by supplementation within the past 6-12 months (documentation must be in the DME provider record and may be requested for state review).
6. The participant meets criterion 3b OR 3c above AND has a medical condition for which the DME provider record contains detailed documentation from the prescribing physician's progress notes justifying the medical necessity of enteral formula.

A list of covered enteral formula HCPCS codes can be found in **Section 5** of this manual. **Section 5** also lists reimbursement requirements (i.e. medical necessity form, IOC) and maximum allowable amounts for each HCPCS code.

Special Enteral Formula

Special nutrient formulas (HCPCS codes B4149, B4153-B4157, B4161 and B4162) are produced to meet unique nutrient needs for specific disease conditions. The DME provider's record for the participant must adequately document the specific condition and the need for the special nutrient. This information shall be made available to the state upon request.

Enteral Nutrition Supplies

Enteral nutrition may be administered by oral intake or by feeding tube via gravity, syringe or pump. Pump administration is covered only when *ONE (1)* of the following criteria is met:

- The patient has a jejunostomy tube
- The patient has a gastrostomy tube or NG tube *AND* the medical record documents *ONE (1)* of the following:
    - A trial and failure of administration by both gravity and syringe or documentation that those methods of administration are medically contraindicated.
    - A pump is medically necessary due to reflux and/or aspiration; severe diarrhea; dumping syndrome; administration rate less than 100 ml/hr; blood glucose fluctuations; or circulatory overload.

The appropriate feeding supply kit must correspond to the prescribed and documented method of administration based on medical need.

2.21 Orthotic Devices

Orthotic devices are covered by MHD when prescribed by a physician (M.D. or D.O.), podiatrist or nurse practitioner. The orthotic device must be necessary and reasonable for the treatment of the participant's illness or injury. The orthotic device must be used to support a weak or deformed body member, or restrict or eliminate motion in a diseased or injured part of the body.

Orthopedic Shoes

Orthopedic shoes and modifications or additions to shoes, are covered only if they are an integral part of a brace, or the participant is diabetic or 20 years of age or under. "Integral" means that the shoes are necessary for completeness of the brace. A pair of shoes may be reimbursed even if only one (1) shoe is an integral part of a unilateral brace.

Shoes for Diabetic Participants

Shoes, inserts and and/or modifications for diabetic participants require pre-certification. DME pre-certification criteria documents may be found on **MHD's website**. Refer to **Section 2.30** for pre-certification guidelines.

A modification of a custom molded or depth shoe may be covered as a substitute for an insert. Although not intended as a comprehensive list, the following are the most common shoe modifications: rigid rocker bottoms (A5503), roller bottoms (A5503), wedges (A5504), metatarsal bars (A5505) or offset heels (A5506). Other modifications of diabetic shoes (A5507) include, but are not limited to, flared heels.

Quantities of shoes, inserts and/or modifications greater than those allowed will be denied.

Inserts used in noncovered shoes are not covered.

Deluxe features of diabetic shoes (A5508) are not covered.

There is no separate reimbursement for certification of need or prescription of footwear, or for fitting of shoes, inserts or modifications.

The particular type of footwear (shoes, inserts, modifications) which is necessary must be prescribed by a podiatrist or physician knowledgeable in the fitting of diabetic shoes and inserts. The footwear must be fitted and furnished by a podiatrist or other qualified individual, such as a pedorthist, orthotist or prosthetist.

The certifying physician provides the medical care for and manages the beneficiary's systemic diabetic condition. The certifying physician must be an M.D. or D.O. and may not be a podiatrist, physician assistant, nurse practitioner or clinical nurse specialist.

Services Included in Reimbursement of Orthotic Devices

The following items are included in the MHD maximum allowable reimbursement for orthotic devices and are not reimbursed separately and may not be billed to the participant:

- Cost of the orthosis;
- Design of the orthosis;
- Required visits or fittings with the provider prior to receiving the orthosis
- Proper fitting of the orthosis

Billing Requirements for Orthotic Devices

Refer to **Section 5** for a list of covered orthotic procedure codes, the MHD maximum allowed amount and the billing guidelines for each procedure code.

2.22 Ostomy Supplies

Non-sterile ostomy supplies are covered for ostomates if prescribed by the participant's attending physician. Ostomy supplies are not covered for participants in a hospital or nursing home. Refer to **Section 5** of this manual for a list of covered ostomy procedure codes, the MHD maximum allowed amount and the quantity limitations for each procedure code.

Noncovered Ostomy Supplies

The following ostomy supplies are not reimbursable under the DME Program:

Absorption Flakes	Absorption Pad	Aerszoin Spray	Allucotton Dressing	Benzoin Tincture
Carrying Case	Catheter Shields	Cellucotton	Chux	Cleansers
Covers	Cutting Tools	Deodorizers	Dilating Glove	Disposable Liners
Drain Eez	Drying Hanger	Drying Rack	Dusting Powder	Enema Bags
Fiberall	Filters	Finger Cots	Flanellets	Foxy Covers
Fresh Tales	Gauze Pads	Gauze Sponges	Germicide	Gloves
Hexon	Incontinent Pads	Lemon Hexon	Nitrazine Paper	Ostomy Skin Bond or Cement Remover
Oxy-Chinol Tablets	Ozium	Spray	Perma-Type	Post-Op Bags
Post-Op Pouches	Post-Op Sets	Skin Barrier Dispensers	Skin Conditioners	Soaking Tray
Spreader	Staphine Spray	Stericol Tablets	Sterile Gloves	Stoma Centering Collars
Stoma Centering Guide	Surgical Sponges	Surge Pads	Syringes	Tape Dispensers
Toppers	Torbot Sanitizer	Travel Bag	Wash Bottle	Waterproof Sheeting

Billing and Reimbursement of Ostomy Supplies

An invoice of the provider's cost for manually-priced ostomy supplies must accompany each CMS-1500 claim for payment. The invoice must be legible, include the price that was paid for the ostomy supply and document the quantity in a box or case. Manually-priced ostomy supplies are reimbursed at the provider's cost plus 20%.

2.23 Oxygen and Respiratory Equipment

Oxygen and respiratory equipment is covered for home use when it is determined to be medically necessary and appropriate and prescribed by the participant's attending physician.

Oxygen

Home oxygen therapy is covered for participants who meet the DME pre-certified medical criteria. DME pre-certification criteria documents may be found on **MHD's website**. Refer to **Section 2.30** for pre-certification guidelines.

If a participant travels out of their provider's usual service area, it is the participant's responsibility to arrange for oxygen during that time period. MHD will only pay one (1) provider for oxygen during any one (1)-rental month.

Certification Requirements

Certification of the need for oxygen therapy will be completed when the authorized prescriber requests pre-certification as indicated below.

- The blood gas study reported for initial certification requests must be the most recent study obtained prior to the pre-certification request. This blood gas study must be obtained within 30 days prior to the date of the pre-certification request.
- For participants' age 21 and older initially meeting criteria in Group I of the medical criteria document and for children meeting criterion 3A of the **medical criteria document**, the most recent qualifying blood gas study prior to the thirteenth month of therapy must be reported on the recertification request. Recertification of Group I participants is required 12 months after the initial certification. If the participant is not seen and reevaluated within 90 days prior to recertification, but is subsequently seen, payment may be made for dates of service between the scheduled recertification date and the physician visit date. No additional certification will be required after the 12-month recertification.
- For participants age 21 and older initially meeting criteria in Group II of the medical criteria document, the most recent blood gas study which was performed between the 61st and 90th day following the initial certification must be reported on the recertification request.
- Recertification of Group II participants is required every three (3) months. Any Group II participant who meets Group I criteria on recertification will be subject to Group I recertification requirements. If a qualifying test is not obtained between the 61st and 90th day of home oxygen therapy, but the participant continues to use oxygen and a test is obtained later, and if that test meets Group I or II criteria, coverage resumes with the date of that test.
- The participant must be seen and evaluated by the treating physician within 30 days prior to the date of the initial certification request. The participant must be seen and reevaluated by the treating physician within 90 days prior to any recertification.
- For any revised certification, the blood gas study reported on the revised certification request must be the most recent test performed prior to the revised date.

- A revised certification is required when there is a change in the type of oxygen delivery system or there is the addition of a portable system to a stationary system.

A revised oxygen therapy certification must be filed when the prescribed maximum flow rate changes from one of the following categories to another:

(a) less than one (1) Liter Per Minute (LPM)

(b) one (1) to four (4) LPM

(c) greater than four (4) LPM

If the change is from category (a) or (b) to category (c), a repeat blood gas study with the participant on four (4) LPM must be performed within 30 days prior to the start of the greater than four (4) LPM flow rate.

Testing Specifications

The qualifying blood gas study must be performed by a physician or a qualified provider of laboratory services. Blood gas studies performed by a provider of oxygen equipment are not acceptable. In addition, the qualifying blood gas study may not be paid for by any provider of oxygen equipment.

For sleep oximetry studies, the oximeter provided to the participant must be tamper-proof and must have the capability to download data that allows documentation of the duration of oxygen desaturation below a specified value.

When oxygen therapy meets criteria based on an oxygen study obtained during exercise, there must be documentation of three (3) oxygen studies in the participant's medical record – i.e., testing at rest without oxygen, testing during exercise without oxygen and testing during exercise with oxygen applied (to demonstrate the improvement of the hypoxemia).

The qualifying blood gas study may be performed while the participant is on oxygen as long as the gas values meet the Group I or Group II criteria.

Modifier

The monthly payment amount for stationary oxygen is subject to adjustment depending on the gen prescribed (LPM) and whether or not portable oxygen is also prescribed.

If a participant qualifies for additional payment for greater than four (4) LPM of oxygen and also meets the requirement for portable oxygen, payment will not be made for the portable oxygen. The provider must use the QF modifier on the stationary code.

The following modifiers must be used when billing oxygen for a participant who requires more than four (4) LPM:

- QF – greater than four (4) LPM and portable oxygen is prescribed
- QG – greater than four (4) LPM

Oxygen Contents

Reimbursement for portable oxygen contents, gas and liquid, may be reimbursed in addition to the portable system, one (1) time per month.

Oxygen contents are not billable with any type of stationary oxygen system rental.

Oxygen Therapy Not Covered

- Angina pectoris in the absence of hypoxemia
- Dyspnea without cor pulmonale or evidence of hypoxemia
- Severe peripheral vascular disease resulting in clinically evident desaturation in one (1) or more extremities but in the absence of systemic hypoxemia. There is no evidence that increased PO2 will improve the oxygenation of tissues with impaired circulation.
- Terminal illnesses that do not affect the respiratory system

Oxygen Supplies, Maintenance and Repair

Cannulas, masks, or any supply used with an oxygen concentrator, portable or stationary oxygen system is included in the monthly rental of that device and is not paid for separately.

Delivery, set-up, maintenance and repair fees are also included in the monthly rental reimbursement and are not paid for separately.

Portable Oxygen Systems

Portable oxygen systems are only covered for participants when both criteria below are met:

- The qualifying ABG/oximetry testing is performed at rest or exercise.
- There is a physician prescription for portable oxygen.

The provider record must include a description of the activities or exercise routine (e.g., amount and frequency of ambulation) that the participant undertakes on a regular basis, and that requires the portable system in the home (i.e., the documentation must describe the medical therapeutic purpose to be served by the portable system that cannot be met by a stationary system).

Ventilator

A volume ventilator or pressure support ventilator may be covered by MHD if prescribed and pre-certified by the participant's attending physician. DME pre-certification criteria documents may be found on **MHD's website**. Refer to **Section 2.30** for pre-certification guidelines.

The monthly reimbursement includes, but is not limited to, the following:

- All Circuits, Brackets and Filters

- Ambu Bag
- Batteries and Battery Charger
- Cleaning Solution and Supplies
- Initial Set-Up and Participant Training
- Maintenance of the Ventilator
- Professional Support
- Trach Care Supplies not billable separately (see below)
- Ventilator Unit

Non-invasive ventilators such as Bi-level Positive Airway Pressure Spontaneously Timed (BiPAP ST) may not be billed under the ventilator code.

Equipment and supplies that may be billed in addition to a ventilator when medically appropriate and necessary are:

- Humidifiers
- Oxygen, Oxygen Concentrators and Oxygen Delivery Systems
- Suction Pumps
- Supplies to include sterile saline water, trach suction catheters, inner cannula, suction tube, oropharyngeal suction catheter, trachea care kit, larynx tube cuffed and uncuffed and collar holder.

Ventilators are covered for participants residing in a nursing home.

Back-Up Ventilator

A back-up ventilator may be covered if a volume or pressure support ventilator has been previously pre-certified and the participant requires ventilation 24 hours per day. The monthly rental reimbursement shall include all items and services as listed for the ventilator.

For participants residing in a nursing home, a back-up ventilator is included in the nursing home per diem rate and is not paid separately.

A back-up ventilator requires pre-certification. DME pre-certification criteria documents may be found on **MHD's website**. Refer to **Section 2.30** for pre-certification guidelines.

Ventilator, Non-Invasive

A non-invasive ventilator may be covered if prior authorized and the participant meets the following conditions:

- Neuromuscular disease or thoracic restrictive diseases or chronic respiratory failure consequent to chronic obstructive pulmonary disease or bronchopulmonary dysplasia (BPD)
- ABG's PaC02 > 45 or PFT with FEV1 < 50%

- Medical records must rule out BiPAP (***EXAMPLE***: Patient requires a volume-targeted mode. Patient requires AVAPS-AE, IVAPS, etc. to achieve adequate ventilation.)

The choice of an appropriate treatment plan, including the determination to use a ventilator vs. a BiPAP device, is made based upon the specifics of each individual beneficiary's medical condition. There must be sufficient detailed information in medical record to justify the treatment selected. Claims for ventilator used to provide CPAP or bi-level CPAP therapy will be denied as not reasonable and necessary.

Nebulizer, Compressor, Suction Pump and Intermittent Positive Pressure Breathing Machine

Delivery, set-up, maintenance, pick-up and repair are included in the monthly rental reimbursement and are not reimbursed separately. All supplies, with the exception of disposable breathing circuits (A4618) for an IPPB, are also included in the monthly rental reimbursement and are not reimbursed separately.

Two (2) nebulizer administration sets per month are allowed for participant-owned nebulizers.

For respiratory equipment that has been purchased through monthly rental payments or has been purchased outright, supplies for this equipment, with the exception of a nebulizer kit, may be requested through the Exceptions Process. Refer to the Exception Manual for more information.

Nebulizers, compressors and suction pumps require pre-certification. DME pre-certification criteria documents may be found on **MHD's website**. Refer to **Section 2.30** for pre-certification guidelines.

Apnea Monitor

Apnea monitors are defined as cardiorespiratory monitoring devices capable of providing continuous or periodic two-channel monitoring of heart rate and respiratory rate and must meet current Food and Drug Administration (FDA) guidelines for products in this class. Apnea monitors must have alarming mechanisms to alert caregivers of cardiorespiratory distress or other events which require immediate intervention and must be capable of recording and storing events and of providing event recording downloads or printouts of such data.

Apnea monitors may be authorized for infants. An infant is described as a child whose age ranges from birth to 12 months of age. Infant Cardiopulmonary Resuscitations (CPR) training of caregivers by certified trainers is recommended.

The following diagnosis or conditions alone are not indications for monitoring, and are not covered:

- Seizure disorders (without life threatening events)
- Hydrocephalus, uncomplicated
- Mental Retardation

- Irreversible terminal conditions
- Congenital heart defects, with or without associated arrhythmias
- Distant family history of apnea or SIDS (other than an immediate sibling)
- History of an apnea monitor use with other siblings
- History of apnea with other sibling(s)
- Parental anxiety or family member request of a monitor
- Monitoring of blood oxygen saturation

Apnea monitors require pre-certification. DME pre-certification criteria documents may be found on **MHD's website**. Refer to **Section 2.30** for pre-certification guidelines.

Apnea Monitor Reimbursement

Apnea monitors are reimbursed on a rental basis. The maximum months of rental which may be reimbursed for an apnea monitor is limited to a total of 12 months. Pre-certification is required for months one (1) through four (4). Additional pre-certification is required for months five (5) through 12. For the appropriate procedure code, reference **Section 5**.

All supplies such as electrodes, wires and belts are included in the monthly rental reimbursement and are not reimbursed separately. Repair, maintenance, initial set-up, event recording, pnuemogram and professional support are also included in the monthly rental reimbursement.

2.24 Respiratory Assist Devices and Continuous Positive Airway Pressure Devices

A Respiratory Assist Device (RAD) that is rented by MHD for 22 or more months is considered purchased. A CPAP device that is rented for 24 or more months is considered purchased. No further rental payments are made and providers may only bill for supplies and repairs needed for continued use after the initial rental period. If utilization of the RAD or CPAP device is discontinued at any time, the provider must stop billing for the equipment, related accessories and supplies.

RAD and CPAP devices require pre-certification. DME pre-certification criteria documents may be found on **MHD"s website**. Refer to **Section 2.30** for pre-certification guidelines.

Coverage for a Continuous Positive Airway Pressure Device (E0601 RR)

A single-level CPAP device (E0601 RR) may be covered if the participant has a diagnosis of Obstructive Sleep Apnea (OSA) documented by an attended, facility-based polysomnogram or an unattended sleep study and is pre-certified. MHD will only cover unattended sleep studies that meet the following criteria:

- A home sleep apnea test must be used, with technically adequate devices, for the diagnosis of OSA in uncomplicated adult patients presenting with signs and symptoms that indicate an increased risk of moderate to severe OSA.

- A home sleep apnea test must not be used for general screening of asymptomatic populations.
- A home sleep apnea test must not be used for the diagnosis of OSA in patients with significant cardiorespiratory disease, potential respiratory muscle weakness due to neuromuscular condition, awake hypoventilation or suspicion of sleep related hypoventilation, chronic opioid medication use, history of stroke or severe insomnia.
- A home sleep apnea test must not be used for the diagnosis of OSA in children.
- When an initial polysomnogram is negative and clinical suspicion for OSA remains, a second polysomnogram must be considered for the diagnosis of OSA.

Continued Coverage for a Continuous Positive Airway Pressure Device Beyond the First Three (3) Months (E0601 KJ RR)

Continued coverage for a CPAP device beyond the first three (3) months of therapy requires that, no sooner than the 61st day after initiating therapy, the DME provider ascertains from either the participant or the treating physician that the participant is continuing to use the CPAP device. This information must be documented in the DME provider's record. If this criterion is met, pre-certification must be obtained and services should be billed utilizing the KJ modifier.

If the above criterion is not met, continued rental coverage of the device is not approved.

Coverage for a Respiratory Assist Device (E0470 and E0471) for the First Three (3) Months of Therapy

The treating physician must be qualified by virtue of experience and training in non-invasive respiratory assistance to order and monitor use of a RAD. Physicians who treat participants for other medical conditions may or may not be so qualified and if not, though they may be the treating physician of the participant for other conditions, they are not considered the treating physician for the prescribing of Non-invasive Positive Pressure Respiratory Assistance (NPPRA) therapy.

In order for a RAD (E0470 or E0471) to be covered, the treating physician must fully document in the participant's medical record symptoms characteristic of sleep-associated hypoventilation, such as daytime hypersomnolence, excessive fatigue, morning headache, cognitive dysfunction, dyspnea, etc., in addition to a copy of the polysomnogram.

A RAD (E0470 or E0471) used to administer NPPRA therapy is covered for participants with clinical disorder groups characterized as restrictive thoracic disorders (i.e., progressive neuromuscular diseases or severe thoracic cage abnormalities), severe Chronic Obstructive Pulmonary Disease (COPD), Central Sleep Apnea (CSA) or OSA (E0470 only) and participants that meet criteria in the **DME pre-certification criteria document**.

Polysomnographic studies must be performed in a facility-based sleep study laboratory, not in the home and may not be performed by a DME provider. Portable multi-channel home sleep testing devices are also not acceptable.

Continued Coverage Criteria for a Respiratory Assist Device Beyond the First Three (3) Months of Therapy

Participants covered for the first three (3) months of a RAD without a backup rate feature (E0470) or a RAD with a backup rate feature (E0471) must be reevaluated to establish the medical necessity of continued coverage by MHD. While the participant may certainly need to be evaluated at earlier intervals after therapy is initiated, the reevaluation upon which MHD will base a decision to continue coverage beyond this time must occur no sooner than 61 days after initiating therapy by the treating physician. MHD will not continue coverage for the 4th and succeeding months of NPPRA therapy until this reevaluation has been completed.

Continued coverage for RAD beyond the first three (3) months of therapy requires additional pre-certification. If the medical criteria is met, services should be billed utilizing the KJ modifier for months four (4) through 22.

Supplies for Respiratory Assist Devices and Continuous Positive Airway Pressure Devices

Supplies used with RAD and CPAP devices are covered when the coverage criteria for the device is met. If the coverage criteria is not met, the supplies are noncovered. Repairs and maintenance are included in the rental reimbursement for the first 22 months for RAD and the first 24 months for CPAP devices and are not reimbursed separately. Providers must not dispense supplies based solely on quantity limitations. The participant must agree that replacement of supplies is desired and necessary; no automatic shipping of supplies is allowed.

The supplies provided must be based on the type of delivery system the participant utilizes. Supplies billed that are inconsistent with the delivery system utilized by the participant are subject to denial or recoupment.

Procedure codes A7044 (oral interface used with positive airway pressure device, each) and A7045 (exhalation port with or without swivel used with accessories for positive airway devices, replacement only) are covered up to one every 180 days; however, these items are rarely needed.

A non-heated (E0561) or heated humidifier (E0562) is covered separately when ordered by the treating physician and pre-certified for use with a covered BiPAP device. A replacement water chamber for a humidifier used with a positive airway pressure device (A7046) may also be covered (a maximum of one per 180 days) when this replacement item is medically necessary.

2.25 Tubed Insulin Pump

To meet the criteria for tubed insulin pumps (E0784) the participant must:

- Have a diagnosis of Diabetes Mellitus
- Have been on a maintenance program for at least six (6) months involving at least three (3) injections of insulin per day and frequent self-adjustments of insulin dosage
- Have performed glucose self-testing at least six (6) times per day on average or using a continuous glucose monitor (CGM) in the past (3) three months
- Have at least one (1) of the following symptoms or conditions:
    - Glycated hemoglobin level (HbA1c) greater than 7%
    - A history of recurring hypoglycemia
    - Wide fluctuations in blood glucose before mealtime
    - A marked early morning increase in fasting blood sugar (dawn phenomenon-glucose level exceeds 200 mg/dl)
    - A history of severe glycemic fluctuations

2.26 Prosthetic Devices

Prosthetic devices (excluding dentures, hearing aids and artificial eyes) are covered by MHD when prescribed by a physician (M.D./D.O) and when the device replaces all or a portion of the function of a permanently inoperative or malfunctioning body member.

Prosthetic Socks and Sheaths

Prosthetic socks and sheaths are limited to six (6) socks and six (6) sheaths per limb per ply (single ply, three (3) ply or five (5) ply), per six (6)-month period.

The participant must have, but not be limited to, moderate to extreme volume fluctuations, higher than normal dermatology risk or wear and tear of previous supply that is putting the member at high risk of skin disturbance.

Mastectomy Bras and Breast Prosthesis

Mastectomy bras are limited to three (3) per year, per participant.

Silicone breast prostheses are limited to one (1) per side, every 24 months. Form prostheses are limited to one (1) per side every six (6) months.

Mastectomy bras and breast prosthesis require pre-certification. DME pre-certification criteria documents may be found on **MHD's website**. Refer to **Section 2.30** for pre-certification guidelines.

The modifier LT (left) or RT (right) along with the appropriate procedure code must be used when submitting a claim for a breast prosthesis. If filing for a bilateral prosthesis, bill on two (2) separate lines of the claim form.

Services Included in Reimbursement

The following items/services are included in the MHD maximum allowable reimbursement for a prosthetic device:

- Cost of the prosthesis
- Design of the prosthesis
- Required visits or fittings with the provider prior to receiving the prosthesis;
- Proper fitting of the prosthesis
- All necessary post-fitting and adjustment visits for one (1) year after receiving the prosthesis
- Necessary modifications for one (1) year after receiving the prosthesis, unless the required because of physical growth or excessive stump shrinkage
- One-year warranty to cover defects in materials and workmanship

Refer to **Section 5** for a complete list of covered prosthetic codes, the MHD maximum allowed amount and the billing guidelines for each procedure code.

2.27 Urological Supplies

Urinary catheters and external urinary collection devices may be covered to drain or collect urine for all ages who have permanent impairment of urination (i.e. permanent urinary incontinence or permanent urinary retention). Permanent urinary retention is defined as retention that is not expected to be medically or surgically corrected in that patient within three (3) months. This does not require a determination that there is no possibility that the patient's condition may improve sometime in the future. If the medical record, including the judgment of the authorized prescriber, indicates the condition is of long and indefinite duration (at least three (3) months), the test of permanence is considered met.

Urological supplies are covered for participants who meet the DME pre-certified medical criteria. DME pre-certification criteria documents may be found on **MHD's website**. Refer to **Section 2.30** for pre-certification guidelines.

Urological supplies codes that require pre-certification (A4331, A4357, A4402 and A5102) must use the modifiers AU NU. Billing with the NU only will limit the approval to codes that contain an ostomy diagnosis.

Indwelling Catheters

No more than one (1) catheter per month is covered for routine catheter maintenance. Non-routine catheter changes may be covered after MHD medical consultant review when documentation substantiates medical necessity, such as for the following indications:

- Catheter is accidentally removed
- Malfunction of catheter
- Catheter is obstructed by encrustation, mucous plug, or blood clot
- History of recurrent obstruction or urinary tract infection for which it has been established that an acute event is prevented by a scheduled change frequency of more than once per month

An all-silicone catheter (A4344, A4312, or A4315) is covered when there is documentation in the patient's medical record of sensitivity to latex.

The authorized prescriber must contact the Pharmacy and Medical Pre-Certification Helpdesk at (800) 392-8030 to request authorization of a specialty indwelling catheter (A4340) or a three (3)-way indwelling catheter (A4346).

Catheter Insertion Tray

One insertion tray is covered per episode of indwelling catheter insertion.

One intermittent catheter with insertion supplies (A4353) is covered per episode of medically necessary sterile intermittent catheterization.

Urinary Drainage Collection System

Payment is made for routine changes of the urinary drainage collection system as indicated in Section 5 of the DME provider manual. The Pharmacy and Medical Pre-Certification Helpdesk must be contacted by the authorized prescriber at (800) 392-8030 to request quantities above the maximum quantity listed.

Leg bags are indicated for patients who are ambulatory or chair/wheelchair bound. The use of leg bags for bedridden patients is not medically necessary.

If there is a catheter change (A4314-A4316, A4354) and an additional drainage bag (A4357) change within a month, the combined utilization for A4314-A4316, A4354 and A4357 must be considered. ***Example:*** if one (1) unit of A4314 and one (1) unit of A4357 are provided, this should be considered as two (2) drainage bags, which is the usual maximum quantity of drainage bags needed for routine changes.

Approval is limited to either a vinyl leg bag (A4358) or a latex leg bag (A5112). The use of both is not medically necessary.

The Pharmacy and Medical Pre-Certification Helpdesk must be contacted by the authorized prescriber at (800) 392-8030 to request authorization of the following items:

- A5200: Percutaneous catheter/tube anchoring device, adhesive skin attachment
- A5102: Bedside drainage bottle with or without tubing, rigid or expandable, each
- A4356: External urethral clamp or compression device, each

Intermittent Irrigation of Indwelling Catheters

Supplies for intermittent irrigation of an indwelling catheter are covered when they are used on an as needed (non-routine) basis in the presence of acute obstruction of the catheter. The medical record must document the presence of acute catheter obstruction. Routine intermittent irrigations are not medically necessary. Routine irrigations are defined as those performed at predetermined intervals. The authorized prescriber must contact the Pharmacy and Medical Pre-Certification Helpdesk at (800) 392-8030 for authorization of intermittent irrigation supplies.

Continuous Irrigation of Indwelling Catheters

Continuous irrigation of indwelling catheters is rarely medically necessary. The authorized prescriber must contact the Pharmacy and Medical Pre-Certification Helpdesk at (800) 392-8030 to request supplies for continuous irrigation of indwelling catheters.

Intermittent Catheterization

Intermittent catheterization is covered when basic coverage criteria are met and the patient or caregiver can perform the procedure.

Intermittent catheterization using a sterile intermittent catheter kit (A4353) is covered when the patient requires catheterization and the patient meets one of the following criteria:

- The patient is immunosuppressed, including but not limited, to:
    - Patient is receiving a regimen of immunosuppressive drugs post-transplant.
    - Patient is receiving cancer chemotherapy.
    - Patient has AIDS.
    - Patient has a drug-induced state such as chronic oral corticosteroid use.
- The patient has a radiologically documented vesico-ureteral reflux while on a program of intermittent catheterization.
- The patient is a pregnant spinal cord injured female with neurogenic bladder (for the duration of the pregnancy only).
- The patient has had distinct urinary tract infections, while on a program of sterile intermittent catheterization with A4351/A4352 and sterile lubricant (A4332), twice in the 12-month period prior to the initiation of sterile intermittent catheter kits.

Refer to **Section 5** for the maximum supply quantities. The authorized prescriber must contact the Pharmacy and Medical Pre-Certification Helpdesk at (800) 392-8030 to request supplies in excess of the maximum allowed.

External Catheters/Urinary Collection Devices

Male external catheters (condom-type) or female external urinary collection devices are covered for patients who have permanent urinary incontinence when used as an alternative to an indwelling catheter.

The authorized prescriber must contact the Pharmacy and Medical Pre-Certification Helpdesk at (800) 392-8030 for authorization of specialty type male external catheters (A4326) such as those that inflate or include a faceplate or extended wear catheter systems. Authorization of a urinary suspensory (A5105) will also require the authorized prescriber to contact the help desk.

Refer to **Section 5** for the maximum quantity of supplies. The authorized prescriber must contact the Pharmacy and Medical Pre-Certification Helpdesk at (800) 392-8030 to request supplies in excess of the maximum quantity allowed.

Miscellaneous Supplies (A4335)

The authorized prescriber must contact the Pharmacy and Medical Pre-Certification Helpdesk at (800) 392-8030 for authorization of A4335 (incontinence supply; miscellaneous).

2.28 Wheelchairs

Standard, power and custom wheelchairs are covered by MHD when determined to be medically appropriate and necessary and prescribed by the participant's attending physician.

Standard Wheelchairs

Standard wheelchairs are covered when the participant's condition is such that the alternative is chair or bed confinement. A **CMN** is required for the purchase or rental of a manual wheelchair. Refer to **Section 5** for a complete list of covered codes and the MHD maximum allowed amount.

Manual Wheelchair Basic Equipment Package

Manual wheelchairs are required to include certain items as part of the basic equipment package. There is no separate reimbursement for these items at the time of initial issue.

To keep in alignment with Medicare guidelines, below is a list of items included in the basic equipment package for manual wheelchairs.

- Seat width: 15"-19"
- Seat depth: 15"-19"
- Calf rests

- Wheel lock assembly
- Hand rims
- Upholstery
- Bearings
- Complete set of tires and casters (with the exception of the items listed below that can be billed separately)
    - Insert for pneumatic propulsion tire (removable), any type
    - Foam-filled propulsion tire, any size
    - Foam-filled caster tire, any size
    - Foam propulsion tire, any size
    - Foam caster tire, any size
    - Front caster assembly with solid tire
    - Armrests: fixed, swingaway or detachable; fixed height
    - Footrests: fixed, swingaway or detachable

Manual Wheelchair Rental of Three (3) Months

To allow quicker access to a manual wheelchair (MWC) with a reclining back, for participants age 20 and under, up to a three (3) month rental will be granted. The need must be due to at least one of the following reasons:

- A surgical procedure performed that prevents the participant from a 90 degree flexion of the hips and knees
- Participant has been placed in a Spica cast
- Any proven medically necessary situation where the participant requires immediate access of a short-term basis

The following procedure codes will be allowed for a three (3) month rental or less with the addition of the EP modifier and an approved **CMN** on file:

- E1014 EP RR – reclining back for pediatric size wheelchair
- E1226 EP RR – manual fully reclining back
- E1236 EP RR – manual wheelchair, folding, adjustable, with seating system
- K0001 EP RR – standard wheelchair
- K0002 EP RR – standard hemi (low seat) wheelchair
- K0003 EP RR – lightweight wheelchair
- K0004 EP RR – high strength lightweight wheelchair

If a MWC is needed beyond the three (3)-month rental, a new request will be required following the regular procedure and process.

Push Rim Power Assist Wheels

(MHD will reimburse push rim power assist wheels (procedure code E0986 RR) as a rent-to-purchase item only. The monthly rental fee is $417.60 per month for 12 months, until the purchase price of $5,011.26 is reached.

If the participant's condition changes, is in need of a power wheelchair and the purchase price has not been met, the push rim power assist wheels must be returned to the provider.

Power assist wheels will not be covered for participants residing in nursing facilities.

Qualifying Criteria

The following criteria must be met to obtain power assist wheels for a manual wheelchair:

- The participant's mobility limitation cannot be sufficiently and resolved by the use of an appropriately fitted cane or walker.
- The participant has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility related activities of daily living (MRADL's).
- The participant has been self-propelling in a manual wheelchair for at least one (1) year.
- The participant no longer has sufficient upper extremity function to self-propel an optimally configured manual wheelchair for functional mobility.
- The participant must have a specialty evaluation performed by a licensed/certified medical professional, such as a physical or occupational therapist; or a practitioner who has specific training and experience in rehabilitation wheelchair evaluations. The physical/occupational therapist or practitioner may have no financial relationship with the supplier.
- A RESNA certified Assistive Technology Professional (ATP), employed by the DME provider must have direct, in person, involvement in the wheelchair selection for the beneficiary.
- Documentation must include, in detail, the need for the device for functional mobility.

Power Wheelchairs

Power mobility devices are covered by MHD if prescribed by the participant's attending physician and prior authorized. The participant's condition is such that a power mobility device is medically appropriate and necessary and the participant is unable to propel a manual wheelchair.

Power Wheelchair Basic Equipment Package

Power wheelchairs are required to include certain items as part of the basic equipment package. There is no separate reimbursement at the time of initial issue for these items unless otherwise noted.

To keep in alignment with Medicare guidelines, below is a list of the items included in the basic equipment package for power wheelchairs.

- Lap belt or safety belt (shoulder harness/straps or chest straps/vest may be billed separately)
- Battery charger
- Complete set of tires and casters, any type
- Leg rests (no separate reimbursement if fixed, swingaway, or detachable non-elevating leg rests with or without calf pad are provided, elevating leg rests may be billed separately)
- Footrests/foot platform (no separate reimbursement if fixed, swingaway or detachable footrests or a foot platform without angle adjustment are provided)
- Angle adjustable footplates (no separate reimbursement for Group 1 or 2 power wheelchairs, angle adjustable footplates may be billed separately for Group 3, 4 and 5 power wheelchairs)
- Armrests (no separate reimbursement if fixed, swingaway, or detachable non-adjustable height armrests with arm pad are provided, adjustable height armrests may be billed separately)
- Weight-specific components (braces, bars, upholstery, brackets, motors, gears, etc. as required by participant weight capacity)
- Any seat width and depth (with the exception of the list of items below that may be billed separately for Group 3 and 4 power wheelchairs with a sling/solid seat/back)
    - For Standard Duty, seat width and/or depth greater than 20 inches
    - For Heavy Duty, seat width and/or depth greater than 22 inches
    - For Very Heavy Duty, seat width and/or depth greater than 24 inches
    - For Extra Heavy Duty, no separate billing
- Any back width (with the exception of the items listed below for Group 3 and 4 power wheelchairs with a sling/solid seat/back that may be billed separately)
    - For Standard Duty, back width greater than 20 inches
    - For Heavy Duty, back width greater than 22 inches
    - For Very Heavy Duty, back width greater than 24 inches
    - For Extra Heavy Duty, no separate billing
- Controller and Input device. There is no separate billing/reimbursement if a non-expandable controller and a standard proportional joystick (integrated or remote) is provided. An expandable controller, a non-standard joystick (i.e., nonproportional or mini, compact or short throw proportional), or other alternative control device may be billed separately.

Non-standard seat dimensions and non-standard back dimensions should be billed with code K0108. No separate billing at the time of initial issue should be submitted for these items unless otherwise noted.

Power Wheelchair Accessories

Wheelchair accessories for power chairs must be billed under the specific code(s). If there is no specific code(s), K0108 may be used. K0108 may only be listed one (1) time on the **PA Request**.

Power-Operated Vehicle (Scooters) Basic Equipment Package

Power-operated vehicles (scooters) are required to include certain items as part of the basic equipment package. There is no separate reimbursement for these items at the time of initial issue.

To keep in alignment with Medicare guidelines, below is a listing of the items included in the basic equipment package for power-operated vehicles.

- Battery or batteries required for operation
- Battery charger
- Weight appropriate upholstery and seating system
- Tiller steering
- Non-expandable controller with proportional response to input
- Complete set of tires
- All accessories needed for safe operation
- All options and accessories are included in the initial issue

Wheelchair Batteries

Providers may bill up to 30 minutes of labor under K0739 when billing for the replacement of batteries.

Custom Wheelchairs

A custom wheelchair is defined as a chair that is tailor made for one (1) participant and cannot be used by anyone else. Custom wheelchairs and accessories are covered if prescribed by the participant's attending physician and prior authorized.

An E1161, manual adult wheelchair with tilt space, is covered for a participant who has absent or impaired sensation in the area of contact with the seating surface or inability to carry out a functional weight shift, or has severe abnormal muscle tone significantly affecting positioning (must be noted and described by the physician in chart note) requiring postural changes within the seating system. The tilt requirement of a provided E1161 will have no less than 35 degrees of tilt.

Custom wheelchairs are covered for participants in a nursing home when certain criteria are met. Refer to **Section 2.12** for additional nursing home guidelines.

Wheelchair Accessories Not Otherwise Listed

Procedure code K0108 may only be used in the following circumstances and always requires a PA.

- When there is no specific accessory code(s) for the wheelchair accessory to be dispensed for custom or standard wheelchairs.

Wheelchair Option/Accessory Replacement and Repair

The following are claim filing requirements for replacement of wheelchair options/accessories.

- The appropriate HCPCS code for the specific option/accessory must be billed. The routing modifier, RB, must always be used when the accessory is a replacement for the same part. The RB modifier and the SC modifier must be used for participants residing in a nursing home.
- The procedure code Z0160 RB or Z0160 RB SC may be used for replacement items that do not have a HCPCS code and have an MSRP of $500 or less. Items with an MSRP greater than $500 must be prior authorized utilizing procedure code K0108 RB and K0108 RB SC.
- Items that are new additions or upgrades to a wheelchair must not be billed with the RB modifier. The RB modifier is only utilized for replacement of existing options/accessories.
- Labor required for replacement of an option or accessory, or repair of a wheelchair maybe billed under the procedure code K0739 RB or K0739 RB SC (repair or non-routine service for DME, other than oxygen, requiring the skill of a technician, labor component, per 15 minutes). One (1) unit of labor is equal to 15 minutes of time.
- A **CMN** is required for most option/accessory replacement codes and labor code. The labor code and option/accessory codes should be included on the same **CMN**. The **CMN** must document the following:
    - Make and model name of the wheelchair
    - Initial date of service for purchase of the wheelchair
    - Medical necessity for replacement for each option/accessory code
    - An explanation of the time involved

Wheelchair Seat and Back Cushions

MHD utilizes the following coverage criteria when reviewing PA Requests for wheelchair seat and back cushions.

A general use seat cushion (E2601, E2602) and a general use wheelchair back cushion (E2611-E2612) may be covered for a participant who has a manual wheelchair or who has a power wheelchair with a sling/solid seat/back that meets MHD coverage guidelines. If the participant has a power-operated vehicle or a power wheelchair with a captain's chair seat, a general use seat and back cushion is not covered.

A skin protection seat cushion (E2603, E2604, E2622, E2623,) is covered for a participant who meets both of the following criteria:

1. The participant has a manual wheelchair or a power wheelchair with a sling/solid seat/back that meets MHD coverage guidelines for it.
2. The participant has either of the following:

    - Current or past history of a pressure ulcer (L89.130, L89.140, L89.150, L89.200, L89.210, L89.220, L89.300, L89.310, L89.320, L89.41) on the area of contact with the seating surface.
    - Absent or impaired sensation in the area of contact with the seating surface or inability to carry out a functional weight shift due to one of the following diagnoses:

B91	E75.02	E75.19	E75.23	E75.25
E75.29	E75.4	E84.2	G10	G11.0
G11.1	G11.2	G11.3	G11.4	G11.8
G112.0	G12.1	G12.20	G12.21	G12.23
G12.24	G12.25	G12.29	G12.8	G12.9
G14	G20	G24.1	G30.0	G30.1
G30.8	G30.9	G31.81	G31.82	G32.0
G35	G36.0	G36.1	G36.8	G36.9
G37.0	G37.1	G37.2	G37.3	G37.4
G37.5	G37.8	G37.9	G71.0	G71.2
G80.0	G80.1	G80.2	G80.3	G80.4
G80.8	G80.9	G81.00	G81.01	G80.01
G81.03	G81.04	G81.10	G81.11	G81.12
G81.13	G81.14	G81.90	G81.91	G81.92
G81.93	G81.94	G82.20	G82.21	G82.22
G82.50	G82.51	G82.52	G82.53	G82.54
G93.89	G93.9	G95.0	G95.11	G95.19
G99.2	I69.051	I69.052	I69.053	I69.054
I69.059	I69.151	I69.152	I69.153	I69.154
I69.159	I69.251	I69.252	I69.253	I69.254
I69.259	I169.351	I69.352	I69.353	I69.354
I69.359	I69.851	I69.852	I69.853	I69.854
I69.859	I69.951	I69.952	I69.953	I69.954
I69.959	M62.3	Q05.0	Q05.1	Q05.2
Q05.3	Q05.4	Q05.5	Q05.6	Q05.7
Q05.8	Q05.9	Q07.01	Q07.02	Q07.03

A positioning seat cushion (E2605, E2606) and positioning back cushion (E2613-E2616, E2620, E2621) are covered for a participant who meets both of the following criteria:

1. The participant has a manual wheelchair or a power wheelchair with a sling/solid seat/back that meets MHD guidelines for it; and

2. The participant has any significant postural asymmetries that are due to a diagnosis listed in the table above or to one of the following diagnoses:

G83.10	G83.11	G8.12	G83.13	G83.14
I69.041	I69.042	I69.043	I69.044	I69.049
I69.141	I69.142	I69.143	I69.144	I69.149
I69.241	I69.242	I69.243	I69.244	I69.249
I69.341	I69.343	I69.344	I69.349	I69.841
I69.842	I69.843	I69.844	I69.849	I69.941
I69.942	I69.943	I69.94	I69.949	

A combination skin protection and positioning seat cushion (E2607, E2608, E2624, E2625) is covered for a participant who meets the criteria for both a skin protection seat cushion and a positioning seat cushion. A custom fabricated seat cushion (E2609) is covered if criteria one (1) and three (3) are met.

A custom fabricated back cushion (E2617) is covered if criteria two (2) and three (3) are met.

1. Participant meets all of the criteria for a prefabricated skin protection seat cushion or positioning seat cushion.
2. Participant meets all of the criteria for a prefabricated positioning back cushion.
3. There is comprehensive written documentation submitted with the PA Request that clearly and specifically explains all of the following:
    - Why a prefabricated system is not sufficient to meet participant's seating and positioning needs
    - What orthopedic deformity is present; and it's fixed or flexible presentation
    - What altered muscle tone is present; and it's increased or decreased presentation that affects seating and positioning
    - Why any existing system is not meeting participant seating and positioning needs

For amputee patients the following positioning cushions will be allowed based solely on an amputee of a lower limb:

- E2605, positioning wheelchair seat cushions, width less than 22 inches
- E2606, positioning wheelchair seat cushions, width greater than 22 inches
- E2607, skin protection and positioning wheelchair cushions, width less than 22 inches
- E2608, skin protection and positioning width less than 22 inches

If the above information is not included with the documentation submitted or if additional documentation is needed, the PA Request is denied and additional information requested.

Custom Molded Seat and Back Cushion Reimbursement

Custom molded wheelchair seat (E2609) and back (E2617) cushions are reimbursed at 90% of the MSRP for manual wheelchairs and 95% of MSRP for power wheelchairs. Charges for all modifications and mounting hardware is added together to determine the total MSRP. Charges for molding fees and other labor charges are not to be included in the MSRP. These charges are not reimbursed separately for cushions for new wheelchairs. Labor is allowed for repairs and replacement cushions.

Documentation for Wheelchair Prior Authorization Requests

Justification must accompany the **PA Request** when requesting a PA for a custom or power wheelchair. Justification must include comprehensive written documentation that clearly and specifically explains all of the following:

- The diagnosis/comorbidities and conditions relating to the need for a custom or power wheelchair
- Description and history of limitations/functional deficits
- Description of physical and cognitive abilities to utilize equipment
- History of previous interventions/past use of mobility device;
- Descriptions of existing equipment, age and specifically why it is not meeting participant needs
- Why a less costly mobility device is unable to meet participant needs (i.e., cane, walker, standard wheelchair)
- Documentation and justification of medical necessity of recommended mobility device, accessories and positioning components
- Documentation/explanation of participant's ability to safely tolerate/utilize the recommended equipment

If the participant has been evaluated by a physical therapist, occupational therapist or in a wheelchair clinic, the information obtained in the evaluation must also be included. The DME provider must ensure that the wheelchair being requested is adequate to meet the participant's physical needs as well as environmental needs (e.g., the wheelchair fits through the doors of the participant's home).

2.29 Prior Authorization

A PA approves the medical necessity of the requested service only. It does not guarantee payment, nor does it guarantee that the amount billed is the amount reimbursed. The participant must be MO HealthNet eligible and eligible for the service on the date of the service or the date the equipment or prosthesis is received by the participant, except when the item is a custom-made item. Please see **Section 2.11 f**or additional information. .

Submission of Durable Medical Equipment Prior Authorization Request

DME PA Requests and supporting documentation must be submitted to MHD's claim processing agent, Wipro Infocrossing. Facsimile (fax) to (573) 659-0207 or mail to:

Wipro Infocrossing
P.O. Box 5900
Jefferson City, MO 65102

Disposition letters for PA Requests received by fax will be returned via the fax number through which the request was sent. Providers are encouraged to ensure requests are sent only from fax numbers that are not blocked. Disposition letters that cannot be successfully returned via fax will be mailed to the provider.

A **PA Request** for an HCY item must clearly be marked as an HCY request.

The following documentation must be included on, or submitted with, the **PA Request** form:

- A detailed explanation from the prescribing physician and/or therapist that includes the nature of the item to be provided, the duration of time the item is needed and the projected outcome the item should provide. Listing only a diagnosis code and description does not provide sufficient information to determine the medical necessity of the item being requested.
- An invoice showing the provider's cost of the item(s) being requested, unless **Section 5.1** indicates that a prior authorized code has a maximum allowed amount established. The invoice must indicate the number of items in a box or case if applicable.

DME items that require PA can be identified by the abbreviation "PA" under the "Reimbursement Guidelines" column in **Section 5** of this manual.

Clarification of Prior Authorization Request for Change

Providers should only submit a Request for Change (RFC) to an approved **PA Request** when there is something on the disposition letter that needs to be corrected, changed or discontinued. Only the disposition letter should be submitted with the changes made directly on the disposition letter. Invoices must be included if a price has changed. A PA change request should be submitted when one or more of the following apply:

- A correction needs to be made to the modifier
- A procedure code needs to be corrected or changed
- A correction or change to the from and/or through date
- An increase or decrease in requested units or dollars
- Services have been discontinued to a participant

DO NOT submit a PA change request for the following situations. A new **PA Request** must be submitted when one or more of the following apply:

- A new item needs to be added to an existing PA Request
- The participant's MO HealthNet number is incorrect (the existing **PA Request** must be closed and a new **PA Request** submitted under the correct number)
- An initial **PA Request** or renewal request is denied and resubmitted with corrections

2.30 Pre-Certification Process for Durable Medical Equipment

Pre-certification serves as a utilization management tool allowing payment for services that are medically necessary, appropriate and cost-effective without compromising the quality of care to participants. Pre-certification of specific items and services will be implemented incrementally by individual HCPCS code or groups of codes.

Pre-certification of DME is a two (2)-step process. Requests for pre-certification must be initiated by an authorized DME prescriber who writes prescriptions for items covered under the DME Program. Authorized DME prescribers include physicians, podiatrists and nurse practitioners who have a collaborative practice agreement with a physician that allows for prescription of such items. Speech pathologists are an authorized prescriber for ACDs only. The enrolled DME provider will access the pre-certification process. All requests must be approved by MHD. Providers are encouraged to sign up for the MHD Web tool - CyberAccess℠ which automates the pre-certification process. To become a CyberAccess℠ user, contact the Conduent help desk at (888) 581-9797 or (573) 632-9797, or send an e-mail to **CyberaccessHelpdesk@conduent.com**. The CyberAccess℠ tool allows each pre-certification to automatically reference the participant's claim history including applicable ICD diagnosis codes and CPT procedure codes. Requests for pre-certification are also received by the Pharmacy and Medical Pre-Certification Helpdesk at (800) 392-8030. Requests for pre-certification must meet medical criteria established by MHD in order to be approved. Medical criteria is published in provider bulletins and posted on the **MHD website** prior to implementation. If a pre-certification request submitted through CyberAccess℠ is denied, providers may contact the MHD call center. The call center is available Monday through Friday from 8:00 a.m. to 5:00 p.m., excluding state holidays.

DME items that require pre-certification are identified by the abbreviation "PC" under the "Reimbursement Guidelines" column in **Section 5** of this manual.

PLEASE NOTE: An approved pre-certification request does not guarantee payment. The provider must verify participant eligibility on the date of service using the Interactive Voice Response (IVR) System at (573) 751-2896 or by logging in to **eMOMED**.

2.31 Durable Medical Equipment Program Billing Reminders

A PA approves the medical necessity of the item. It does not guarantee payment for the item as the participant must be MO HealthNet eligible on the date the equipment is dispensed.

It is the responsibility of the MO HealthNet provider to ascertain the participant's MO HealthNet eligibility status.

Charges for delivery, pick-up, shipping, freight, handling and COD are included in the MHD reimbursement of all purchased or rented equipment, medical supplies, oxygen, orthotics and prosthetics, TPN, IV therapy and enteral therapy and cannot be billed to the participant.

DME provided to participants in a nursing home is not covered under the DME Program with the exception of: volume ventilators, TPN, custom and power wheelchairs, orthotics, prosthetics and ACDs.

Reimbursement for items through the DME Program is the lower of the provider's usual and customary charge or the MHD allowable amount.

For participants with both Medicare and MO HealthNet coverage, a Medicare denial is not required for submitting an MHD claim for volume ventilators for participants in a nursing home.

A **CMN** is valid for six (6) months. A new **CMN** must be completed every six (6) months.

For specific equipment codes and billing requirements refer to **Section 5**.

Medical criteria documents for items requiring pre-certification may be found on **MHD's website**.

2.32 Noncovered Services Under The Durable Medical Equipment Program

Noncovered Items

MHD does not cover items that primarily serve the following purposes: personal comfort, convenience, education, hygiene, safety, cosmetic, new equipment of unproven value and equipment of questionable current usefulness or therapeutic value.

- Adaptive toys
- Air conditioners
- Back-up manual wheelchairs or stroller to a manual wheelchair (adults & children)
- Bathtub rails
- Canopy/safety beds
- Car seats
- Computers (unless determined to be used for an ACD)
- Dialysis equipment
- Electric bathtub lifts
- Elevators
- Environmental control systems
- Equipment used in non-medical context

- External power or electronic prosthetic devices
- Furniture
- Home modifications
- Labor for the assembling of wheelchairs or equipment
- Massage equipment
- Medical alert system
- Medical necessity bags
- Motivation-type devices
- Multiple positioning equipment such as a mobile floor sitter and a wheelchair with a seating system
- Pacemaker monitor
- Power wheelchair seat elevations system
- Power wheelchair power standing system
- Refrigerators
- Repair, replacement or continued rental of equipment for which a continuing need cannot be established
- Repair to non-covered items are non-covered
- Sales tax
- Seat lift chairs
- Stair lifts or glides
- Standers
- Sunshade/canopies
- Transits option
- Treadmill
- Vehicle Modifications
- Water softening systems
- Wheelchair lifts
- Wheelchair ramps
- Whirlpool tubs or pumps

The above list is not all inclusive. If there is not a specific code listed in Section 5, the item is not covered.

Dual-Eligible Participants in Medicare Competitive Bidding Area

For Medicare beneficiaries whose permanent residence is in a statistical area affected by the competitive bidding area (CBA) Program, only contract suppliers will be eligible to provide competitive bid items and receive payment from Medicare. Complete information on the competitive bidding process can be found on the **CMS website**.

MHD will align policy with Medicare for dual-eligible participants who reside in a CBA. If Medicare denies reimbursement for a DME competitively bid service that was provided to a participant by a non-contract or non-demonstration supplier, the service is not covered by MHD and must not be billed to MHD for reimbursement. The participant is not liable for payment unless the non-contract supplier in a CBA has informed the participant in writing prior to receiving the item that there would be no Medicare or MO HealthNet coverage due to the supplier's contract status, and the participant understands that they will be liable for all costs that the non-contract supplier may charge the participant for the item.

Section 3: Special Documentation Requirements

Program limits may require a Prior Authorization (PA) Request, Certificate of Medical Necessity (CMN) or a pre-certification. Refer to Section 3.2 of this manual for instructions on requesting PA.

The MO HealthNet Program has requirements for other documentation when processing claims under certain circumstances. Refer to Section 5 of this manual for specific documentation requirements.

NOTE: When a specific procedure requires an attachment, the attachment remains a requirement and must accompany the claim form or PA Request.

3.1 Certificate of Medical Necessity

A CMN is required for many DME services. Refer to Section 5 of this manual for a complete list of procedure codes covered under the DME Program and their specific documentation requirements.

The determination of medical necessity is based on the information contained on the CMN. Therefore, it is important that every field on the form be completed. It is also important to include on the CMN the procedure code, a complete description of the item; brand name; model number, if applicable; accessories or components, if applicable; diagnosis; prognosis; the reason why the equipment/ item is needed and the anticipated length of need.

When the medical consultant cannot determine medical necessity based on the information provided, the claim may be denied.

The information captured on the CMN should be submitted electronically utilizing the Attachment Management option on eMOMED. Instructions for completing the CMN can be found on eMOMED utilizing the "?" function in the upper right hand corner of the screen.

3.2 Prior Authorization

Many items covered under the DME Program require prior approval by the MO HealthNet Division (MHD). Refer to Section 8 of the General Sections Manual for complete instructions on completing the PA Request.

Procedure codes that require PA are listed in **Section 5** of this manual.

Requesting Prior Authorization

When requesting PA for approval to dispense certain DME items, providers should submit as much information as possible as to why the specific item is being requested. The information must include the description of the item to be provided, the anticipated length of need, the projected outcome the item should provide and the diagnosis and prognosis of the recipient. If there is not enough room on the **PA Request**, include the information on an additional sheet of paper. The participant's attending physician must sign the **PA Request**. If in **Section 5** it is indicated that a procedure code requires an evaluation or an IOC, those documentation requirements must accompany the **PA Request**.

Return of Prior Authorization Request Forms

The fiscal agent returns a PA determination form to the provider. The **PA Request** determination form is marked approved, denied, or incomplete, meaning additional information is required. MHD allowable reimbursement amount or approved units are entered on the PA determination form.. Authorization expires three (3) months (unless otherwise indicated) following the date of approval. This information is also accessible through **eMOMED.**

Returned/Denied Prior Authorization Request Forms

If the **PA Request** is returned for additional information or for further clarification, the provider is urged to explain in detail or attach as much documentation as possible to support the medical necessity of the item being requested.

3.3 Oxygen and Respiratory Equipment Medical Justification

The Oxygen and Respiratory Equipment Medical Justification (OREMJ) attachment is not required for claims submitted for oxygen and oxygen delivery systems, and should be maintained in the participant's file. A pre-certification must be submitted to request oxygen systems and equipment. Refer to **Section 5** of this manual for specific oxygen codes.

Section 4: Billing Instructions

4.1 CMS-1500 Claim Form

The CMS-1500 claim form is used to bill the MO HealthNet Division (MHD) for Durable Medical Equipment (DME) services. Claims should be submitted electronically through **eMOMED** or a clearinghouse, unless the claim requires special handling or MHD requires a paper claim be submitted. Certificates of Medical Necessity (**CMN**s) and Invoices of Cost (IOCs) are accepted electronically through **eMOMED**. The process outlined in this section applies to submission of paper CMS-1500 claim forms.

The CMS-1500 claim form should be typed or legibly printed. It may be duplicated if the copy is legible. MHD claims should be mailed to:

Wipro Infocrossing
P.O. Box 5900
Jefferson City, MO 65102

NOTE: An asterisk (*) beside field numbers indicates required fields. These fields must be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (**) beside the field number indicate a field is required in specific situations.

Field Number & Name		Instructions for completion
1	Type of Health Insurance Coverage	Show the type of health insurance coverage applicable to this claim by checking the appropriate box. For example, if a Medicare claim is being filed, check the Medicare box, if an MHD claim is being filed, check the Medicaid box and if the participant has both Medicare and MHD, check both boxes.
*1a.	Insured's I.D.	Enter the patient's eight (8)-digit MHD number as shown on the patient's ID card.
*2.	Patient's Name	Enter last name, first name, middle initial in that order as it appears on the ID card.
3	Patient's Birth Date	Enter month, day and year of birth.
	Sex	Mark appropriate box.
**4.	Insured's Name	If there is other insurance besides MHD, enter the name of the primary policyholder. If this field is completed, also complete Fields #6, #7, #11 and #13.
5	Patient's Address	Enter address and telephone number if available.
**6.	Patient's Relationship to Insured	Mark appropriate box if there is other insurance.
**7.	Insured's Address	Enter the primary policyholder's address; enter policyholder's telephone number, if available.
8	Reserved for NUCC Use	

Field Number & Name		Instructions for completion
**9.	Other Insured's Name	Enter other insured's full last name, first name and middle initial of the enrollee in another health plan if it is different from that in Item #2.
**9a.	Other Insured's Policy or Group Number	Enter the secondary policyholder's insurance policy number or group number, if the insurance is through a group such as an employer, union, etc. (See NOTE)(1)
**9b.	Other Insured's Date of Birth	Enter the secondary policyholder's date of birth and mark the appropriate box for sex. (See NOTE)(1)
**9c.	Employer's Name	Enter the secondary policyholder's employer name. (See NOTE)(1)
**9d.	Insurance Plan	Enter the secondary policyholder's insurance plan name. If the insurance plan denied payment for the service provided, attach valid denial from the insurance plan. (See NOTE)(1)
**10a-10c.	Is Condition Related to:	If services on the claim are related to patient's employment, auto accident or other accident, mark the appropriate box. If the services are not related to an accident, leave blank. (See NOTE)(1)
10d.	Reserved for Local Use	May be used for comments/descriptions. (See NOTE)(1)
**11.	Insured's Policy or Group Number	Enter the primary policyholder's insurance policy number or group number, if the insurance is through a group, such as an employer, union, etc. (See NOTE)(1)
**11a.	Insured's Date of Birth sex	Enter primary policyholder's date of birth and mark the appropriate box reflecting the sex of the primary policyholder. (See NOTE)(1)
**11b.	Employer's Name	Enter the primary policyholder's employer name. (See NOTE)(1)
**11c.	Insurance Plan Name	Enter the primary policyholder's insurance plan name. If the insurance plan denied payment for the item provided, attach valid denial from the insurance plan. (See NOTE)(1)
**11d.	Other Health Plan	Indicate whether the participant has another health insurance plan; if so, complete Fields #9-#9d with the secondary insurance information. (See NOTE)(1)
12	Patient's Signature	Leave blank.

Field Number & Name		Instructions for completion
13	Insured's Signature	This field should be completed only when the participant has another health insurance policy. Obtain the policyholder's or authorized person's signature for assignment of benefits. The signature is necessary to ensure the insurance plan pays any benefits directly to the provider or MHD. Otherwise payment may be issued to the policyholder requiring the provider to collect insurance benefits from the policyholder.
14	Date of Current Illness, Injury or Pregnancy	Leave blank.
15	Date Same/Similar Illness	Leave blank.
16	Dates Patient Unable to Work	Leave blank.
**17.	Name of referring provider or Other Source	Enter the name of the referring provider or other source. If multiple providers are involved, enter one provider using the following priority order 1. Referring provider 2. Ordering Provider 3. Supervising Provider
**17a.	Other ID	Enter ID and the MHD legacy number of the provider.
**17b.	NPI	Enter the NPI number of referring, ordering, or supervising provider.
18	Hospitalization Dates	Leave blank.
19	Reserved for Local Use	This field may be used for additional remarks or descriptions.
20	Lab Work Performed Outside Office	Leave blank.
*21.	Diagnosis	Enter the complete applicable ICD CM diagnosis code(s). Enter the primary diagnosis under No. 1, the secondary diagnosis under No. 2, etc.

Field Number & Name		Instructions for completion
22	Medicaid Resubmission	For timely filing purposes, if this is a resubmitted claim, enter the Internal Control Number (ICN) of the previous related claim.
23	Prior Authorization Number	Leave blank.
*24a.	Date of Service	Enter the date of service under "from" in month/day/year format, using six-digit format. All line items must have a from date. A "to" date is required when billing for DME rental, (TOS "T").
*24b.	Place of Service	Enter the appropriate place of service code. 11 Office, Community Health Centers 12 Home 22 Outpatient Hospital 24 Ambulatory Surgical Center 26 Military Treatment Facility 31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 53 Community Mental Health Center 54 Intermiediate Care Facility/Mentally Retarded 61 Comprehensive Inpatient Rehabilitatiion Facility 62 Comprehensive Outpatient Rehabilitation Facility 71 State or Local Publie Health Clinic 97 Non-Public School 98 Public School 99 Other Unlisted Facility
*24c.	EMG-Emergency	Enter the appropriate type of service code for the procedure code billed. The valid TOS codes for DME are: A DME Purchase T DME Rental 0 (Zero) DME Repair, Replacement, or Modification
*24d.	Procedure Code	Enter the appropriate HCPCS code corresponding to the item dispensed. Description of the service is required for DME providers. Enter the description in the modifier field and/or use the next line.
*24e.	Diagnosis Pointer	Enter 1, 2, 3, 4 or the actual diagnosis code(s) from Field #21.

Field Number & Name		Instructions for completion
*24f.	Charges	Enter the provider's usual and customary charge for each line item. This should be the total charge for multiple days or units. When an item has been prior authorized, the amount approved must be billed instead of the usual and customary charge.
*24g.	Days or Units	Enter the number of days or units of service provided for each detail line. The system automatically plugs a "1" if the field is left blank. DME—for DME rental of equipment under the regular DME Program (TOS T), the "from" and "to" dates of service should reflect the month, or portion of the month, in which the item is rented. The quantity must always be a "1." When billing ostomy supplies under procedure code A4421, the quantity is always a "1." Please refer to the specific procedure code instructions in Section 5.
**24h.	EPSDT/Family Planning	If the service is HCY/EPSDT, enter "E."
24i.	ID Qualifier	Enter in the shaded area of 24I, ID. The other ID# of the rendering provider is reported in 24J in the shaded area.
24j.	Rendering Provider ID	Leave blank.
24k.		
25	SS#/Fed. Tax ID	Leave blank.
26	Patient Account Number	For the provider's own information, a maximum of 12 alpha and/or numeric characters may be entered here.
27	Assignment	Not required on MHD claims.
*28.	Total Charge	Enter the sum of the line item charges for each claim form.
29	Amount Paid	Enter the total amount received by all other insurance resources. Previous MHD payments, Medicare payments and copay amounts are not to be entered in this field.
30	Balance Due	Enter the difference between the total charge (Field #28) and the insurance amount paid (Field #29).
31	Provider Signature	Not Required.
**32.	Name and Address of Facility	If equipment was delivered to a facility other than the home or office, enter the name and location of the facility.

Field Number & Name		Instructions for completion
**32a.	NPI#	Enter the 10-digit NPI number of the service facility location in 32.
**32b.	Other ID#	Enter the MHD legacy number.
*33.	Provider Name/ Number/Address	Affix the provider label or write or type the information exactly as it appears on the label.
* These fields are mandatory on all CMS-1500 claim forms.		
** These fields are mandatory only in specific situations, as described.		
(1) NOTE: This field is for private insurance information only. If no private insurance is involved LEAVE BLANK. If Medicare, MHD, employers name or other information appears in this field, the claim will deny. See Section 5 for further TPL information.		

4.2 Billing Procedures for Medicare/MO HealthNet

When a participant has both Medicare Part B and MHD coverage, a claim must be filed with Medicare first as primary payer. Medicare Part B claims are sent to MHD from Medicare automatically if the service is covered by Medicare.

The claim will crossover electronically to MHD on a Medicare CMS-1500 Part B Professional Claim (Crossover Claim). The claim will provide any adjustments or patient responsibility reported by Medicare. MHD pays the Medicare coinsurance and deductible for Medicare-covered services.

If the patient has Medicare Part B and Medicare denies the claim as noncovered, the provider reports the Medicare denial on the other payer portion of a CMS-1500 claim when billing MHD. MHD will pay up to the MHD allowable for MHD covered services.

Medicare Part C claims do not crossover to MHD. Medicare Part C claims are processed based on the participant's eligibility for the Qualified Medicare Beneficiary (QMB) benefit.

If the participant has Medicare Part C with QMB coverage and Medicare Part C pays, MHD pays the Medicare coinsurance and deductible for Medicare-covered services. Providers should submit a Medicare CMS-1500 Part C Professional QMB (Crossover Claim) claim electronically.

If the participant has Medicare Part C without QMB coverage MHD will **not** pay the Medicare coinsurance and deductible. Providers should report the Medicare payment or nonpayment on the electronic CMS-1500 claim. MHD will pay up to the MHD allowable for MHD covered services.

All MHD requirements such as Prior Authorization (PA), **CMN** and IOC are required when billing on a CMS-1500 claim. **PA**s, **CMN**s or IOCs are not required when billing on a crossover claim. See section 5 for specific code requirements.

Claims for wheelchair bases, accessories and repairs for nursing home participants who are not under a Medicare Part A nursing home stay, do not require a Medicare Part B denial for the claim to be processed. Diapers, pull-ons and underpads are also exempt from the Medicare Part B denial.

The previous mentioned exemptions are not applicable to those with Medicare Part C coverage. Providers must bill Medicare Part C prior to billing MHD.

Reference the Medicare Medicaid Claims Processing Manual for additional billing instructions.

4.3 Place of Service Codes

Code		Definition
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic or nursing facility, where the health professional routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
22	Outpatient Hospital	The portion of a hospital that provides diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Services Treatment Facilities (USTF).
31	Skilled Nursing Facility (SNF)	A facility that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services that does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility that primarily provides to residents skilled nursing care and related services for the rehabilitation of individuals with injury, disability or illness, or on a regular basis health-related care services above the level of custodial care to other than individuals with developmental disabilities.

Code		Definition
33	Custodial Care Facility	A facility that provides room, board and other personal assistance services, generally on a long-term basis and that does not include a medical component.
34	Hospice	A facility other than a patient's home, in which palliative and supportive care for patients with terminal illness and their families is provided. NOTE: This place of service should only be used when the actual service is performed in a hospice facility. If a hospice patient receives services in a setting other than a hospice facility, then the specific location for that service should be used.
53	Community Mental Health Center (CMHC)	A facility that provides comprehensive mental health services on an ambulatory basis primarily to individuals residing or employed in a defined area.
54	Intermediate Care Facility/ Mentally Retarded	A facility that primarily provides health-related care and services above the level of custodial care to individuals with developmental disabilities but does not provide the level of care or treatment available in a hospital or SNF.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services and orthotics and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
71	State or Local Public Health Clinic	A facility maintained by either state or local health departments that provides ambulatory primary medical care under the general direction of a physician.
97	Non-Public School	A parochial or private school supported by private funds and governed by a private body.
98	Public School	A school open to any child in the community, supported by tax dollars and governed by a local school district.
99	Other Unlisted Facility	Other service facilities not identified above.

4.4 Diagnosis Codes

The diagnosis code is a required field and the accuracy of the code that describes the participant's condition is important.

The diagnosis code must be entered on the claim form exactly as it appears in the applicable ICD-CM. Note that the appropriate code(s) may be three, four or five digits, depending upon the patient's diagnosis. The fourth and fifth digits give greater detail or specificity and must be used as applicable to the patient's diagnosis(es) when available.

Diagnosis codes are not included in this section. Claims may be denied if a three-digit code is used. The applicable ICD-CM may require a fourth or fifth digit. The applicable ICD-CM (Volume I) should be used as a guide in the selection of the appropriate three, four or five digit diagnosis code.

Additional information regarding the applicable ICD-CM may be found on the **Centers for Disease Control and Prevention website**.

Section 5: DME Procedure Codes

This section includes all covered MO HealthNet Durable Medical Equipment (DME) Healthcare Common Procedure Coding System (HCPCS) codes, modifiers, quantities and requirements. The modifiers provided in this section must be on the claim, prior authorization, certificate of medical necessity and invoice of cost.

IOC = Invoice of Cost
CMN = Certificate of Medical Necessity (required to be entered in eMOMED and retained in patient's medical record)
MNF = Medical Necessity on File
PA = Prior Authorization
PC = Pre-Certification
RB = Repair
RR = Rental
NU = Purchase
EP = EPSDT Program (participants under 21)
AU = URO, Ostomy or Trach Item

5.1 Healthy Children and Youth Covered Only for Participants Age 0-20

Procedure Code	Modifiers			Description	Reimbursement Guidelines		Limits Qty/Days and Comments
A4206	NU	EP		1 CC STERILE SYRINGE&NEEDLE	MNF		100/30
A4207	NU	EP		SYRINGE WITH NEEDLE, STERILE 2 CC EACH	MNF		30/30
A4208	NU	EP		SYRINGE WITH NEEDLE, STERILE 3 CC EACH	MNF		100/30
A4209	NU	EP		SYRINGE WITH NEEDLE, STERILE 5 CC OR GREATER, EACH	MNF		100/30
A4211	NU	EP		SUPPLIES FOR SELF-ADMIN INJECT.	PA	IOC	

Procedure Code	Modifiers			Description	Reimbursement Guidelines		Limits Qty/Days and Comments
A4212	NU	EP		NON-CORING NEEDLE OR SYLET W/WO CATHETER	MNF		15/30
A4213	NU	EP		SYRINGE STERILE 20CC OR GREAT, EACH	MNF		100/30
A4215	NU	EP		NEEDLE, STERILE, ANY SIZE, EACH	MNF		100/30
A4216	NU	EP		STERILE WATER/SALINE, 10 ML	MNF		100/30
A4217	NU	EP		STERILE WATER/SALINE, 500 ML	MNF		30/30
A4221	NU	EP		SUPP NON-INSULIN INF CATH/WK			1/7
A4222	NU	EP		SUPPLIES FOR EXTERNAL DRUG INFUSION PUMP, PER CASSETTE OR BAG LIST DRUG SEPARATELY			
A4223	NU	EP		INFUSION SUPPLIES NOT USED WITH INFUSION PUMP, PER CASSETTE/BAG	CMN	IOC	
A4224	NU	EP		SUPPLY INSULIN INF CATH/WK	MNF		1/7
A4225	NU	EP		SUP EXT INSULIN INF PUMP SYR	MNF		
A4244	NU	EP		ALCOHOL OR PEROXIDE, PER PINT			1/30
A4245	NU	EP		ALCOHOL WIPES, PER BOX			1/30
A4246	NU	EP		BETADINE OR PHISOHEX SOLUTION, PER PINT	MNF		2/30
A4247	NU	EP		BETADINE OR IODINE SWABS/WIPES, PER BOX	MNF		2/30
A4248	NU	EP		CHLORHEXIDINE CONTAINING ANTISEPTIC, 1 ML	MNF		2/30
A4330	NU	EP		PERIANAL FECAL COLLECTION POUCH WITH ADHESIVE, EACH	MNF		30/30
A4400	NU			OSTOMY IRRIGATION SET	MNF		1/90
A4450	NU	EP		TAPE, NON-WATERPROOF, PER 18 SQUARE INCHES			10/30
A4452	NU	EP		TAPE, WATERPROOF, PER 18 SQUARE INCHES			10/30
A4461	NU	EP		SURGICAL DRESSING HOLDER, NON-REUSABLE, EACH			8/30

Procedure Code	Modifiers			Description	Reimbursement Guidelines		Limits Qty/Days and Comments
A4463	NU	EP		SURGICAL DRESSING HOLDER, REUSABLE, EACH	IOC		1/30
A4465	NU	EP		NON-ELASTIC BINDER FOR EXTREMITY	MNF		2/30
A4480	NU	EP		VABRA ASPIRATOR	MNF		
A4481	NU	EP		TRACH FILTER ANY TYPE ANY SZ, EA	MNF		30/30
A4520	NU			INCONT. GARMENT, ANY TYPE, EACH	PC		186/30, NON-COVERED FOR CHILDREN 3 YEARS AND UNDER
A4520	NU	EP		INCONT. GARMENT, ANY TYPE, EACH	PC		+186/30 NON-COVERED FOR CHILDREN 3 YEARS AND UNDER
A4550	NU	EP		SURGICAL TRAYS	MNF		12/30
A4554	NU			DISPOSABLE UNDERPADS, ALL SIZES	PC	IOC	186/30, NON-COVERED FOR CHILDREN 3 YEARS AND UNDER
A4554	NU	EP		DISPOSABLE UNDERPADS, ALL SIZES	PC	IOC	+186/30, NON-COVERED FOR CHILDREN 3 YEARS AND UNDER
A4605	NU	EP		TRACHEAL SUCTION CATHETER, CLOSED SYSTEM, EACH	MNF		13/30
A4606	NU	EP		OXYGEN PROBE USED W OXIMETER, DISPOSABLE	MNF		10/30
A4614	NU	EP		PEAK EXPIRATORY FLOW RATE METER, HAND HELD	MNF		
A4623	NU	EP		TRACH, INNER CANNULA REPLACE ONLY	MNF		8/30
A4624	NU	EP		TRACH SUCTION TUBE	MNF		90/30

Procedure Code	Modifiers			Description	Reimbursement Guidelines		Limits Qty/Days and Comments
A4625	NU	EP		TRACH CARE KT FOR NEW TRACH	MNF		1/1
A4626	NU	EP		TRACH CLEANING BRUSH, EACH	MNF		2/30
A4628	NU	EP		OROPHARYNGEAL SUCT. CATH, EACH	MNF		1/30
A4629	NU	EP		TRACH CARE KIT FOR EST. TRACH	MNF		1/1
A4649	NU	EP		SURGICAL SUPPLY, MISCELLANEOUS	PA	MSRP	
A4657	NU	EP		SYRINGE, WITH OR WITHOUT NEEDLE, EACH	MNF		4/30
A4660	NU	EP		SPHYGMOMANOMETER/BLOOD PRESSURE APPARATUS WITH CUFF AND STETHOSCOPE	MNF		1/365
A4663	NU	EP		BLOOD PRESSURE CUFF ONLY	MNF		1/30
A4670	NU	EP		AUTOMATIC BLOOD PRESSURE MONITOR	MNF		1/365
A4927	NU	EP		NON-STERILE GLOVES, PER 100	MNF		2/30
A4930	NU	EP		GLOVES, STERILE, PER PAIR	MNF		30/30
A5120	NU	EP		SKIN BARRIER, WIPES OR SWABS, EACH	MNF		30/30
A5121	NU	EP		SKIN BARRIER; SOLID, 6X6 OR EQUIVALENT, EACH			20/30
A5122	NU	EP		SKIN BARRIER; SOLID, 8X8 OR EQUIVALENT, EACH			20/30
A5126	NU	EP		ADHESIVE OR NON-ADHESIVE; DISK OR FOAM PAD			20/30
A5200	NU	EP	BA	PERCUTANEOUS CATHETER/TUBE ANCHORING DEVICE, ADHESIVE SKIN ATTACHMENT	PC		1/30
A6000	NU	EP		NON-CONTACT WOUND WARMING WOUND COVER FOR USE WITHNON-CONTACT WOUND WARMING DEVICE AND WARMING CARD	PA	IOC	
A6000	RR	EP		NON-CONTACT WOUND WARMING WOUND COVER FOR USE WITHNON-CONTACT WOUND WARMING DEVICE AND WARMING CARD	PA	IOC	

Procedure Code	Modifiers			Description	Reimbursement Guidelines		Limits Qty/Days and Comments
A6010	NU	EP		COLLAGEN BASED WOUND FILLER	MNF		30/30
A6011	NU	EP		COLLAGEN GEL/PASTE WOUND FIL	MNF		30/30
A6021	NU	EP		COLLAGEN DRESSING <=16 SQ IN	MNF		30/30
A6022	NU	EP		COLLAGEN DRSG>16<=48 SQ IN	MNF		30/30
A6023	NU	EP		COLLAGEN DRESSING >48 SQ IN	MNF		30/30
A6024	NU	EP		COLLAGEN DSG WOUND FILLER	MNF		30/30
A6025	NU	EP		SILICONE GEL SHEET, EACH	CMN	IOC	
A6154	NU	EP		WOUND POUCH, EACH	MNF		30/30
A6196	NU	EP		ALGINATE DRESSING <=16 SQ IN	MNF		30/30
A6197	NU	EP		ALGINATE DRSG >16 <=48 SQ IN	MNF		30/30
A6198	NU	EP		ALGINATE DRESSING > 48 SQ IN	MNF		
A6199	NU	EP		ALGINATE DRSG WOUND FILLER	MNF		30/30
A6203	NU	EP		COMPOSITE DRSG <= 16 SQ IN	MNF		12/30
A6204	NU	EP		COMPOSITE DRSG >16<=48 SQ IN	MNF		12/30
A6205	NU	EP		COMPOSITE DRSG > 48 SQ IN	MNF		
A6206	NU	EP		CONTACT LAYER <= 16 SQ IN	MNF		4/30
A6207	NU	EP		CONTACT LAYER >16<= 48 SQ IN	MNF		4/30
A6208	NU	EP		CONTACT LAYER > 48 SQ IN	MNF		

Procedure Code	Modifiers			Description	Reimbursement Guidelines		Limits Qty/Days and Comments
A6209	NU	EP		FOAM DRSG <=16 SQ IN W/O BDR	MNF		12/30
A6210	NU	EP		FOAM DRG >16<=48 SQ IN W/O B	MNF		12/30
A6211	NU	EP		FOAM DRG > 48 SQ IN W/O BRDR	MNF		12/30
A6212	NU	EP		FOAM DRG <=16 SQ IN W/BORDER	MNF		12/30
A6213	NU	EP		FOAM DRG >16<=48 SQ IN W/BDR	MNF		12/30
A6214	NU	EP		FOAM DRG > 48 SQ IN W/BORDER	MNF		12/30
A6215	NU	EP		FOAM DRESSING WOUND FILLER	MNF		
A6216	NU	EP		GAUZE, NON-IMPREGNATED/STERILE, 16 SQ IN OR LESS, W/O ADHESIVE BORDER, EACH DRESSING			60/30
A6217	NU	EP		GAUZE, NON IMPREGNATED, NON/STERILE 16 SQ IN OR LESS	MNF		90/30
A6218	NU	EP		GAUZE NON-IMPREG, NON-STERILE PAD MORE THAN 48 SQ IN	MNF		
A6219	NU	EP		GAUZE <= 16 SQ IN W/BORDER	MNF		30/30
A6220	NU	EP		GAUZE >16 <=48 SQ IN W/BORDR	MNF		30/30
A6221	NU	EP		GAUZE > 48 SQ IN W/BORDER	MNF		30/30
A6222	NU	EP		GAUZE <=16 IN NO W/SAL W/O B	MNF		30/30
A6223	NU	EP		GAUZE >16<=48 NO W/SAL W/O B	MNF		30/30
A6224	NU	EP		GAUZE > 48 IN NO W/SAL W/O B	MNF		30/30
A6228	NU	EP		GAUZE <= 16 SQ IN WATER/SAL	MNF		30/30
A6229	NU	EP		GAUZE >16<=48 SQ IN WATR/SAL	MNF		30/30

Procedure Code	Modifiers			Description	Reimbursement Guidelines		Limits Qty/Days and Comments
A6230	NU	EP		GAUZE > 48 SQ IN WATER/SALNE	MNF		30/30
A6231	NU	EP		HYDROGEL DSG<=16 SQ IN	MNF		30/30
A6232	NU	EP		HYDROGEL DSG>16<=48 SQ IN	MNF		30/30
A6233	NU	EP		HYDROGEL DRESSING >48 SQ IN	MNF		
A6234	NU	EP		HYDROCOLLD DRG <=16 W/O BDR	MNF		12/30
A6235	NU	EP		HYDROCOLLD DRG >16<=48 W/O B	MNF		12/30
A6236	NU	EP		HYDROCOLLD DRG > 48 IN W/O B	MNF		12/30
A6237	NU	EP		HYDROCOLLD DRG <=16 IN W/BDR	MNF		12/30
A6238	NU	EP		HYDROCOLLD DRG >16<=48 W/BDR	MNF		12/30
A6239	NU	EP		HYDROCOLLD DRG > 48 IN W/BDR	MNF		12/30
A6240	NU	EP		HYDROCOLLD DRG FILLER PASTE	MNF		30/30
A6241	NU	EP		HYDROCOLLOID DRG FILLER DRY	MNF		30/30
A6242	NU	EP		HYDROGEL DRG <=16 IN W/O BDR	MNF		30/30
A6243	NU	EP		HYDROGEL DRG >16<=48 W/O BDR	MNF		30/30
A6244	NU	EP		HYDROGEL DRG >48 IN W/O BDR	MNF		12/30
A6245	NU	EP		HYDROGEL DRG <= 16 IN W/BDR	MNF		12/30
A6246	NU	EP		HYDROGEL DRG >16<=48 IN W/B	MNF		12/30
A6247	NU	EP		HYDROGEL DRG > 48 SQ IN W/B	MNF		12/30
A6248	NU	EP		HYDROGEL DRSG GEL FILLER	MNF		30/30

Procedure Code	Modifiers			Description	Reimbursement Guidelines		Limits Qty/Days and Comments
A6251	NU	EP		ABSORPT DRG <=16 SQ IN W/O B	MNF		30/30
A6252	NU	EP		ABSORPT DRG >16 <=48 W/O BDR	MNF		30/30
A6253	NU	EP		ABSORPT DRG > 48 SQ IN W/O B	MNF		30/30
A6254	NU	EP		ABSORPT DRG <=16 SQ IN W/BDR	MNF		15/30
A6255	NU	EP		ABSORPT DRG >16<=48 IN W/BDR	MNF		15/30
A6256	NU	EP		ABSORPT DRG > 48 SQ IN W/BDR	MNF		
A6257	NU	EP		TRANSPARENT FILM <= 16 SQ IN	MNF		12/30
A6258	NU	EP		TRANSPARENT FILM >16<=48 IN	MNF		12/30
A6259	NU	EP		TRANSPARENT FILM > 48 SQ IN	MNF		12/30
A6260	NU	EP		WOUND CLEANSER ANY TYPE/SIZE	CMN	IOC	
A6261	NU	EP		WOUND FILLER GEL/PASTE /OZ	MNF		
A6262	NU	EP		WOUND FILLER DRY FORM / GRAM	MNF		
A6266	NU	EP		IMPREG GAUZE NO H20/SAL/YARD	MNF		
A6402	NU	EP		GAUZE, NON-IMPREG. STERILE, PAD SZ 16 SQ IN OR LESS	MNF		100/30
A6403	NU	EP		GAUZE, NON IMPREG STERILE PAD SIZE MORE THAN 16 SQ IN	MNF		100/30
A6404	NU	EP		GAUZE ELASTIC STERILE ALL TYPES, PER LINEAR YARD	MNF		
A6407	NU	EP		PACKING STRIPS, NON-IMPREG	MNF		100/30
A6441	NU	EP		PADDDING BANDAGE W >=3 <5 /YD	MNF		90/30
A6442	NU	EP		CONFROM BAND S/S W<3 /YD	MNF		180/30
A6443	NU	EP		CONFROM BAND N/S W>=3 <5 /YD	MNF		180/30

Procedure Code	Modifiers			Description	Reimbursement Guidelines		Limits Qty/Days and Comments
A6444	NU	EP		CONFORM BAND N/S W>=5 /YD	MNF		180/30
A6445	NU	EP		CONFORM BAND S W < 3 /YD	MNF		180/30
A6446	NU	EP		CONFORM BAND S W >=3 < 5 /YD	MNF		180/30
A6447	NU	EP		CONFORM BAND S W >= 5 /YD	MNF		180/30
A6448	NU	EP		LT COMP BAND <3 /YD	MNF		12/30
A6449	NU	EP		LT COMP BAND >=3 <5 /YD	MNF		12/30
A6450	NU	EP		LT COMP BAND >+ =5 /yd	MNF		12/30
A6451	NU	EP		MOD COMP BAND W>=3 <5 /YD	MNF		12/30
A6452	NU	EP		HIGH COMP BAND W >= 3 <5 YD	MNF		12/30
A6453	NU	EP		SELF-ADHER BAND W<3 /YD	MNF		12/30
A6454	NU	EP		SELF ADHER BAND W >=3 <5 /YD	MNF		12/30
A6455	NU	EP		SELF ADHER BAND >=5 /YD	MNF		12/30
A6456	NU	EP		ZINC PASTE BAND W>=3 <5 /YD	MNF		12/30
A6457	NU	EP		TUBULAR DRESSING W/WO ELASTIC, ANY WDTH, PER LINEAR YARD			12/30
A6460	NU	EP		SYNTHETIC DRSG <= 16 sq in	PA, IOC		
A6461	NU	EP		SYNTHETIC DRSG >16<=48 sq in	PA, IOC		
A6501	NU	EP		COMPRESS BURN GARMENT BODYSUIT	MNF		
A6502	NU	EP		COMPRESS BURN GARMENT CHINSTRP	CMN	IOC	
A6503	NU	EP		COMPRES BURN GARMENT FACE HOOD	MNF		
A6504	NU	EP		COMPRES BURN GARMENT GLOVE-WRIST	CMN	IOC	
A6505	NU	EP		COMPRES BURN GARMENT GLOVE - ELBOW	CMN	IOC	

Procedure Code	Modifiers			Description	Reimbursement Guidelines		Limits Qty/Days and Comments
A6506	NU	EP		COMPRES BURN GARMENT GLOVE AXILLA	CMN	IOC	
A6507	NU	EP		COMPRES BURN GARMENT FOOT-KNEE	MNF		
A6508	NU	EP		COMPRES BURN GARMENT FOOT - THIGH	CMN	IOC	
A6509	NU	EP		COMPRESS BURN GARMENT JACKET	CMN	IOC	
A6510	NU	EP		COMPRESS BURN GARMENT LEOTARD	CMN	IOC	
A6511	NU	EP		COMPRESS BURN GARMENT PANTY	MNF		
A6512	NU	EP		COMPRESS BURN GARMENT, NOC	CMN	IOC	
A6513	NU	EP		COMPRESSION BURN MASK, FACE AND/OR NECK PLASTIC OR =, CUSTOM	IOC	IOC	
A6530	NU	EP		GRADIENT COMPRESSION STOCKING, BELOW KNEE, 18-30 MMHG, EACH	IOC	IOC	
A6531	NU	EP		GRADIENT COMPRESSION STOCKING, BELOW KNEE, 30-40 MMHG, EACH			
A6532	NU	EP		GRADIENT COMPRESSION STOCKING, BELOW KNEE, 40-50 MMHG, EACH			
A6533	NU	EP		GRADIENT COMPRESSION STOCKING, THIGH LENGTH, 18-30 MMHG, EACH	IOC		
A6534	NU	EP		GRADIENT COMPRESSION STOCKING, THIGH LENGTH, 30-40 MMHG, EACH	IOC		
A6535	NU	EP		GRADIENT COMPRESSION STOCKING, THIGH LENGTH, 40-50 MMHG, EACH	IOC		
A6536	NU	EP		GRADIENT COMPRESSION STOCKING, FULL LENGTH/CHAP STYLE, 18-30 MMHG, EACH	IOC		
A6537	NU	EP		GRADIENT COMPRESSION STOCKING, FULL LENGTH/CHAP STYLE, 30-40 MMHG, EACH	IOC		

Procedure Code	Modifiers			Description	Reimbursement Guidelines		Limits Qty/Days and Comments
A6538	NU	EP		GRADIENT COMPRESSION STOCKING, FULL LENGTH/CHAP STYLE, 40-50 MMHG,EACH	IOC		
A6539	NU	EP		GRADIENT COMPRESSION STOCKING, WASTE LENGTH, 18-30 MMHG, EACH	IOC		
A6540	NU	EP		GRADIENT COMPRESSION STOCKING, WASTE, LENGTH, 30-40 MMHG, EACH	IOC		
A6541	NU	EP		GRADIENT COMPRESSION STOCKING, WASTE, LENGTH, 40-50 MMHG, EACH	IOC		
A6544	NU	EP		GRADIENT COMPRESSION STOCKING, GARTER BELT	IOC		
A6545	NU	EP		GRADIENT COMPRESSION WRAP, NON-ELASTIC, BELOW KNEE, 30-50 MM HG, EACH	IOC		
A6549	NU	EP		G COMPRESSION STOCKING	PA	IOC	
A6550	NU	EP		NEG PRES WOUND THER DRSG SET	MNF		
A7000	NU	EP		CANNISTER, DISPOSABLE	MNF		2/30
A7002	NU	EP		TUBING	MNF		2/30
A7020	RB	EP		INTERFACE, COUGH STIM DEVICE	CMN	IOC	
A7501	NU	EP		TRACHEOSTOMA VALVE, INCLUDING DIAPHRAM, EACH	MNF		1/120
A7502	NU	EP		REPLACEMENT DIAPHRAM/FACEPLATE FOR TRACHEOSTOMA VALVE, EACH	MNF		
A7503	NU	EP		FILTER HOLDER OR FILTER CAP, REUSE, USE IN TRACH	MNF		
A7504	NU	EP		FLTR FOR USE IN A TRACH HEAT AND MOISTURE EXCHANGE SYSTEM	MNF		
A7505	NU	EP		HOUSING REUSABLE W/O ADHESIVE FOR USE IN A HEAT AND MOISTURE EXCHANGE	MNF		

Procedure Code	Modifiers			Description	Reimbursement Guidelines		Limits Qty/Days and Comments
A7506	NU	EP		ADHESIVE DISC FOR USE IN A HEAT AND MOISTURE EXCHANGE SYSTEM	MNF		30/30
A7507	NU	EP		FLTR HLDR AND INTEGRATED FLTR W/O ADHESIVE FOR USE IN A TRACH	MNF		60/30
A7508	NU	EP		HOUSING AND INTEGRATED ADHESIVE FOR USE IN A TRACH	MNF		1/30
A7509	NU	EP		FILTER HOLDER AND INTEGRATED FILTER HOUSING AND ADHESIVE	MNF		1/30
A7520	NU	EP		TRACH LARYN TUBE NON-CUFFED	MNF	IOC	2/30
A7521	NU	EP		TRACH/LARYN TUBE CUFFED	MNF		2/30
A7522	NU	EP		TRACH LARYN TUBE STAINLESS	MNF		1/30
A7523	NU	EP		TRACHEOSTOMY SHOWER PROTECT	MNF		1/120
A7524	NU	EP		TRACH STENT/STUD/BUTTON	MNF		1/90
A7525	NU	EP		TRACH MASK	MNF		1/30
A7526	NU	EP		TRACH TUBE COLLAR/HOLDER, EACH	MNF		15/30
A7527	NU	EP		TRACH/LARYNGECTOMY TUBE, PLUG, STOP, EACH	MNF		
A8000	NU	EP		HELMET, PROTECTIVE, SOFT, PREFABRICATED, INCLUDES ALL COMPONENTS AND ACCESSORIES	MNF		
A8001	NU	EP		HELMET, PROTECTIVE, HARD, PREFABRICATED, INCLUDES ALL COMPONENTS AND ACCESSORIES	MNF		
A9270	RB	EP		NON-COVERED ITEM OR SERVICE	CMN	IOC	
A9270	NU	EP		NON-COVERED ITEM OR SERVICE	CMN	IOC	
A9270	RR	EP		NON-COVERED ITEM OR SERVICE	CMN	IOC	

Procedure Code	Modifiers			Description	Reimbursement Guidelines		Limits Qty/Days and Comments
A9900	NU	EP		MISCELLANEOUR DME SUPPLY, ACCESSORY, AND/OR SERVICE COMPONENT OF ANOTHER HCPCS CODE	PA	IOC	
A9999	NU	EP		MISC. DME SUPPLY OR ACCESSORY, NOT OTHERWISE SPECIFIED	PA	IOC	
A9999	RR	EP		MISC. DME SUPPLY OR ACCESSORY, NOT OTHERWISE SPECIFIED	PA	IOC	
A9999	RB	EP		MISC. DME SUPPLY OR ACCESSORY, NOT OTHERWISE SPECIFIED	CMN	IOC	
B4034	NU	EP	BA	ENTER FEED SUPKIT SYR BY DAY			DATE SPAN # OF DAYS =# OF UNITS
B4035	NU	EP	BA	ENTERAL FEED SUPP PUMP PER D			DATE SPAN # OF DAYS =# OF UNITS
B4036	NU	EP	BA	ENTERAL FEED SUP KIT GRAV BY			DATE SPAN # OF DAYS =# OF UNITS
B4081	NU	EP	BA	NASOGASTRIC TUBING:WITH SYLET			1/30
B4082	NU	EP	BA	NASOGASTRIC TUBING WITHOUT STYLET			1/30
B4083	NU	EP	BA	STOMACH TUBE, LEVINE TYPE			1/30
B4087	NU	EP	BA	GASTRO/JEJUNO TUBE, STD			1/90
B4088	NU	EP	BA	GASTRO/JEJUNO TUBE, LOW-PRO			1/90
B4100	NU	EP	BO	FOOD THICKENER ORAL	MNF		
B4103	NU	EP	BA	ENTERAL FORMULA, FOR PEDS, USED TO REPLACE FULIDS AND ELECTROLYTES, 500ml = 1 UNIT	MNF		MUST BE OVER WIC ALLOTMENT
B4103	NU	EP	BO	ENTERAL FORMULA, FOR PEDS, USED TO REPLACE FULIDS AND ELECTROLYTES, 500ml = 1 UNIT	MNF		MUST BE OVER WIC ALLOTMENT
B4104	NU	EP	BA	FIBER ADDITIVE FOR ENTERAL FORMULA		IOC	

Procedure Code	Modifiers			Description	Reimbursement Guidelines		Limits Qty/Days and Comments
B4104	NU	EP	BO	FIBER ADDITIVE FOR ENTERAL FORMULA		IOC	
B4149	NU	EP	BA	ENTERAL FORMULA, MANUFACTURED BLENDERIZED NATURAL FOODS WITH INTACT NUTRIENTS, INCLUDES PROTEINS, 100 VALORIES - 1 UNIT	MNF		MUST BE OVER WIC ALLOTMENT
B4149	NU	EP	BO	ENTERAL FORMULA, MANUFACTURED BLENDERIZED NATURAL FOODS WITH INTACT NUTRIENTS, INCLUDES PROTEINS, 100 CALORIES = 1UNIT	MNF		MUST BE OVER WIC ALLOTMENT
B4150	NU	EP	BA	CATEGORY I SEMI-SYNTH PROTEIN ISOLATES 100 CALORIES = 1 UNIT	MNF		MUST BE OVER WIC ALLOTMENT
B4150	NU	EP	BO	CATEGORY I SEMI-SYNTH PROTEIN ISOLATES 100 CALORIES = 1 UNIT	MNF		MUST BE OVER WIC ALLOTMENT
B4152	NU	EP	BA	CATEGORY II INTACT PROTEIN ISOLATES CALORICALLY DENSE 100 CALORIES = 1 UNIT	MNF		MUST BE OVER WIC ALLOTMENT
B4152	NU	EP	BO	CATEGORY II INTACT PROTEIN ISOLATES CALORICALLY DENSE 100 CALORIES = 1 UNIT	MNF		MUST BE OVER WIC ALLOTMENT
B4153	NU	EP	BA	CATEGORY III HYDROLYZED PROTEIN AA 100 CALORIES = 1 UNIT	MNF		MUST BE OVER WIC ALLOTMENT
B4153	NU	EP	BO	CATEGORY III HYDROLYZED PROTEIN AA 100 CALORIES = 1 UNIT	MNF		MUST BE OVER WIC ALLOTMENT
B4154	NU	EP	BA	CATEGORY IV FORM FOR SPECIAL METABOLIC NEED 100 CALORIES = 1 UNIT	MNF		MUST BE OVER WIC ALLOTMENT
B4154	NU	EP	BO	CATEGORY IV FORM FOR SPECIAL METABOLIC NEED 100 CALORIES = 1 UNIT	MNF		MUST BE OVER WIC ALLOTMENT
B4155	NU	EP	BA	CATEGORY V MODULAR COMPONENTS 100 CALORIES = 1 UNIT	MNF		MUST BE OVER WIC ALLOTMENT
B4155	NU	EP	BO	CATEGORY V MODULAR COMPONENTS 100 CALORIES = 1 UNIT	MNF		MUST BE OVER WIC ALLOTMENT

Procedure Code	Modifiers			Description	Reimbursement Guidelines		Limits Qty/Days and Comments
B4157	NU	EP	BA	NUTRITION COMPLETE, FOR SPECIAL METABOLIC NEEDS, 100 CALORIES = 1 UNIT		IOC	MUST BE OVER WIC ALLOTMENT
B4157	NU	EP	BO	NUTRITION COMPLETE, FOR SPECIAL METABOLIC NEEDS, 100 CALOREIS = 1 UNIT		IOC	MUST BE OVER WIC ALLOTMENT
B4158	NU	EP	BA	ENTERAL FORMULA, FOR PEDS, NUTRITIONALLY COMPLETE WITH INTACT NUTRIENTS, 100 CALORIES = 1 UNIT		IOC	MUST BE OVER WIC ALLOTMENT
B4158	NU	EP	BO	ENTERAL FORMULA, FOR PEDS, NUTRITIONALLY COMPLETE WITH INTACT NUTRIENTS, 100 CALORIES = 1 UNIT		IOC	MUST BE OVER WIC ALLOTMENT
B4159	NU	EP	BA	ENTERAL FORMULA FOR PEDS, NUTRITION, COMPLETE SOY BASED W/INTACT, 100 CALORIES = 1 UNIT		IOC	MUST BE OVER WIC ALLOTMENT
B4159	NU	EP	BO	ENTERAL FORMULA FOR PEDS, NUTRITION, COMPLETE SOY BASED W/INTACT, 100 CALORIES = 1 UNIT		IOC	MUST BE OVER WIC ALLOTMENT
B4160	NU	EP	BA	ENTERAL FORMULA FOR PEDS NUTRITION COMPLETE CALORICALLY DENSE, 100 CALORIES = 1 UNIT	MNF		MUST BE OVER WIC ALLOTMENT
B4160	NU	EP	BO	ENTERAL FORMULA FOR PEDS NUTRITION COMPLETE CALORICALLY DENSE, 100 CALORIES = 1 UNIT	MNF		MUST BE OVER WIC ALLOTMENT
B4161	NU	EP	BA	ENTERAL FORMULA FOR PEDS NUTRITION COMPLETE CALORICALLY DENSE, 100 CALORIES = 1 UNIT	MNF		MUST BE OVER WIC ALLOTMENT
B4161	NU	EP	BO	ENTERAL FORMULA FOR PEDS NUTRITION COMPLETE CALORICALLY DENSE, 100 CALORIES = 1 UNIT	MNF		MUST BE OVER WIC ALLOTMENT
B4162	NU	EP	BA	ENTERAL FORMULA FOR PEDS NUTRITION COMPLETE CALORICALLY DENSE, 100 CALORIES = 1 UNIT	MNF	IOC	MUST BE OVER WIC ALLOTMENT
B4162	NU	EP	BO	ENTERAL FORMULA FOR PEDS NUTRITION COMPLETE CALORICALLY DENSE, 100 CALORIES = 1 UNIT	MNF	IOC	MUST BE OVER WIC ALLOTMENT
B9002	NU	EP	BA	ENTER NUTR INF PUMP ANY TYPE			
B9998	NU	EP	BA	NOC FOR ENTERAL SUPPLIES		IOC	

Procedure Code	Modifiers			Description	Reimbursement Guidelines		Limits Qty/Days and Comments
B9998	NU	EP	BO	NOC FOR ENTERAL SUPPLIES		IOC	
E0171	NU	EP		COMMODE CHAIR WITH INTEGRATED SEAT LIFT MECHANISM,NON-ELECTRIC, ANY TYPE	PA	IOC	
E0171	RR	EP		COMMODE CHAIR WITH INTEGRATED SEAT LIFT MECHANISM,NON-ELECTRIC, ANY TYPE	PA	IOC	
E0172	NU	EP		SEAT LIFT MECHANISM PLACED OVER OR ON TOP OF TOILET, ANY TYPE	PA	IOC	
E0202	RR	EP		PHOTOTHERAPY (BILIRUBIN) LIGHT WITH PHOTOMETER	MNF		MAXIMUM OF 6 DAYS
E0231	NU	EP		NON-CONTACT WOUND WARMING DEVICE (TEMP CNTRL, AC ADAPTER & POWER CORD), USE W/WARMING CARD & COVER	PA	IOC	
E0231	RR	EP		NON-CONTACT WOUND WARMING DEVICE (TEMP CNTRL, AC ADAPTER, POWER CORD), USE W/WARMING CARD AND COVER	PA	IOC	
E0232	NU	EP		WARMING CARD, USE W/NON-CONTACT WOUND WARMING DEVICE & NON-CONTACT WOUND WARMING WOUND COVER	PA	IOC	
E0232	RR	EP		WARMING CARD, USE W/NON-CONTACT WOUND WARMING DEVICE & NON-CONTACT WOUND WRMING WOUND COVER	PA	IOC	
E0240	NU	EP		BATH/SHOWER CHAIR W/WO WHEELS, ANY SIZE	PA	IOC	
E0240	RR	EP		BATH/SHOWER CHAIR W/WO WHEELS, ANY SIZE	PA	IOC	
E0240	RB	EP		BATH/SHOWER CHAIR W/WO WHEELS, ANY SIZE	CMN	IOC	
E0328	NU	EP		PED HOSPITAL BED, MANUAL	PA	IOC	
E0328	RR	EP		PED HOSPITAL BED, MANUAL	PA	IOC	
E0328	RB	EP		PED HOSPITAL BED, MANUAL	CMN	IOC	
E0329	NU	EP		PED HOSPITAL BED SEMI/ELECT	PA	IOC	

Procedure Code	Modifiers			Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E0329	RR	EP		PED HOSPITAL BED SEMI/ELECT	PA	IOC	
E0329	RB	EP		PED HOSPITAL BED SEMI/ELECT	CMN	IOC	
E0350	NU	EP		CONTROL UNIT FOR ELECTRONIC BOWEL IRRIGATION/ EVACUATION SYSTEM	PA	IOC	
E0350	RR	EP		CONTROL UNIT FOR ELECTRONIC BOWEL IRRIGATION/ EVACUATION SYSTEM	PA	IOC	
E0352	NU	EP		DISPOSABLE PACK-WATER RESERVOIR BAG, SPECULUM, VALVING MECHANISM & COLLECT BAG/BOX-USE W/E0350	PA	IOC	
E0445	RB	EP		OXIMETER NON-INVASIVE	CMN		
E0445	RR	EP		OXIMETER NON-INVASIVE	PC		12 MONTH RENT TO PURCHASE
E0482	RB	EP		COUGH STIMULATING DEVICE, ALTERNATING POSITIVE AND NEGATIVE AIRWAY PRESSURE, REPAIR ONLY	CMN	IOC	
E0482	RR	EP		COUGH STIMULATING DEVICE, ALTERNATING POSITIVE ANDNEGATIVE AIRWAY PRESSURE, RENTAL	PC		12 MONTH RENT TO PURCHASE
E0483	RR	EP		HIGH FREQUENCY CHEST WALL OSCILLATION AIR-PULSE GENERATOR SYSTEM-INCLUDES HOSES AND VEST-EACH	PC		12 MONTH RENT TO PURCHASE
E0484	NU	EP		OSCILLATORY POSITVE EXPIRATORY PRESSURE DEVICE, NON-ELECTRIC, ANY TYPE, EACH	MNF		
E0484	RR	EP		OSCILLATORY POSITIVE EXPIRATORY PRESSURE DEVICE, NON-ELECTRIC, ANY TYPE, EACH, RENTAL	MNF		
E0485	NU	EP		ORAL DEVICE/APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY	PA	IOC	
E0602	RR	EP		BREAST PUMP, MANUAL, ANY TYPE	MNF		
E0603	RR	EP		BREAST PUMP, ELECTRIC AC/DC, ANY TYPE	PA	IOC	

Procedure Code	Modifiers			Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E0617	NU	EP		EXTERNAL DEFIBRILLATOR W/INTEGRATED ELECTROCARDI-OGRAM ANALYSIS	PA	IOC	
E0638	NU	EP		STANDING FRAME SYS	PA	IOC	
E0638	RB	EP		STANDING FRAME SYS	CMN	IOC	
E0641	NU	EP		MULTI-POSITION STND FRAM SYS	PA	IOC	
E0641	RB	EP		MULTI-POSITION STND FRAM SYS	CMN	IOC	
E0642	NU	EP		DYNAMIC STANDING FRAME	PA	IOC	
E0705	NU	EP		TRANSFER DEVICE	CMN		
E0720	NU	EP		TENS, TWO LEAD, LOCALIZED STIMULATION	PA		
E0730	NU	EP		TENS; FOUR OR MORE LEADS, FOR MULTIPLE NERVE STIMULATION	PA		
E0731	NU	EP		FORM FITTING CONDUCTIVE GARMENT FOR DELIVERY OF TENS/NMES-W/LAYERS OF FABRIC SEPARATING FROM SKIN	PA		
E0744	NU	EP		NEUROMUSCULAR STIMULATOR FOR SCOLIOSIS	PA	IOC	
E0744	RR	EP		NEUROMUSCULAR STIMULATOR FOR SCOLIOSIS	PA	IOC	
E0745	NU	EP		NEUROMUSCULAR STIMULATOR, ELECTRONIC SHOCK UNIT	PA	IOC	
E0745	RR	EP		NEUROMUSCULAR STIMULATOR, ELECTRONIC SHOCK UNIT	PA	IOC	
E0747	NU	EP		OSTEOGENESIS STIMULATOR; ELECTRICAL, NON-INVASIVE,OTHER THAN SPINAL APPLICATIONS	PA		
E0747	RR	EP		OSTEOGENESIS STIMULATOR; ELECTRICAL, NON-INVASIVE,OTHER THAN SPINAL APPLICATIONS	PA		
E0748	NU	EP		OSTEOGENISIS STIMULATOR; ELECTRICAL, NON-INVASIVE,SPINAL APPLICATIONS	PA		

Procedure Code	Modifiers			Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E0748	RR	EP		OSTEOGENISIS STIMULATOR; ELECTRICAL, NON-INVASIVE,SPINAL APPLICATIONS	PA		
E0762	NU	EP		TRANSCUTANEOUS ELECTRICAL JOINT STIMULATION DEVICE SYSTEM	PA	IOC	
E0764	NU	EP		FUNCTIONAL NEUROMUSCULAR STIMULATOR, TRANSUTANEOUS STIMULATION OF MUSCLES	PA		
E0764	RR	EP		FUNCTIONAL NEUROMUSCULARSTIM	PA		
E0769	NU	EP		ELECTRICAL STIMULATION OR ELECTROMAGNETIC WOUND TREATMENT DEVICE	PA	IOC	
E0769	RR	EP		ELECTRICAL STIMULATION OR ELECTROMAGNETIC WOUND TREATMENT DEVICE	PA	IOC	
E0770	NU	EP		FUNCTIONAL ELECTRICAL STIMULATOR, TRANSCUTANEOUS STIMULATION OF NERVE AND/OR	PA	IOC	
E0770	RR	EP		FUNCTIONAL ELECTRICAL STIMULATOR, TRANSCUTANEOUS STIMULATION OF NERVE AND/OR	PA	IOC	
E0770	RB	EP		FUNCTIONAL ELECTRICAL STIMULATOR, TRANSCUTANEOUS STIMULATION OF NERVE AND/OR	CMN	IOC	
E0776	NU	EP		IV POLE			PURCHASE
E0776	NU	EP	BA	IV POLE			PURCHASE
E0776	RR	EP		IV POLE			RENTAL
E0776	RR	EP	BA	IV POLE			RENTAL
E0781	NU	EP		AMB.INFUSION PUMP, SINGLE OR MULTI CHANNELS ELEC/BATTERY OPERATED WITH ADMIN. EQUIP. WORN BY PATIENT			
E0849	RR	EP		TRACTION EQUIPMENT, CERVICAL , FREE STANDING	MNF		

Procedure Code	Modifiers			Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E0870	NU	EP		TRACTION FRAME ATTACHED TO FOOTBOARD, EXTREMITY TRACTION (E.G. BUCK'S)	PA	IOC	
E0870	RR	EP		TRACTION FRAME ATTACHED TO FOOTBOARD, EXTREMITY TRACTION (E.G. BUCK'S)	PA	IOC	
E0911	NU	EP		TRAPEZE BAR, HEAVY DUTY, FOR PATIENT WEIGHT CAPACITY GREATER THAN 250 LBS ATTACHED TO BED	PA	IOC	
E0911	RR	EP		TRAPEZE BAR, HEAVY DUTY, FOR PATIENT WEIGHT CAPACITY GREATER THAN 250 LBS ATTACHED TO BED	PA	IOC	
E0912	NU	EP		TRAPEZE BAR, HEAVY DUTY, FOR PATIENT WEIGHT CAPACITY GREATER THAN 250 LBS FREE STANDING	PA	IOC	
E0912	RR	EP		TRAPEZE BAR, HEAVY DUTY, FOR PATIENT WEIGHT CAPACITY GREATER THAN 250 LBS FREE STANDING	PA	IOC	
E1014	RR	EP		RECLINING BACK FOR PEDIATRIC SZ CHAIR	CMN		
E1037	NU	EP		TRANSPORT CHAIR, PEDIATRIC SIZE	PA	IOC	
E1037	RR	EP		TRANSPORT CHAIR, PEDIATRIC SIZE	PA	IOC	
E1037	RB	EP		TRANSPORT CHAIR, PEDIATRIC SIZE	CMN	IOC	
E1038	NU	EP		TRANSPORT CHAIR, ADULT SIZE, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	PA	IOC	
E1038	RR	EP		TRANSPORT CHAIR, ADULT SIZE, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	PA	IOC	
E1038	RB	EP		TRANSPORT CHAIR, ADULT SIZE, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	CMN	IOC	
E1226	RR	EP		MANUAL FULLY RECLINING BACK	CMN		LIMITED TO A 3 MONTH RENTAL
E1236	RR	EP		FOLDING PEDIACTRIC CHAIR ADJUSTABLE	CMN		LIMITED TO A 3 MONTH RENTAL

Procedure Code	Modifiers			Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E1372	NU	EP		IMMERSION EXTERNAL HEATER FOR NEBULIZER	PA	IOC	
E1372	RR	EP		IMMERSION EXTERNAL HEATER FOR NEBULIZER	PA	IOC	
E1399	RB	EP		DME, MISC	PA	IOC	
E1399	NU	EP		DME, MISC	PA	IOC	
E1399	RR	EP		DME, MISC	PA	IOC	
E2000	NU	EP		GASTRIC SUCTION PUMP	PA	IOC	
E2000	RR	EP		GASTRIC SUCTION PUMP	PA	IOC	
E2402	RB	EP		NEG PRESS WOUND THERAPY PUMP	PA	IOC	
E2402	NU	EP		NEG PRESS WOUND THERAPY PUMP	PA	IOC	
E2402	RR	EP		NEG PRESS WOUND THERAPY PUMP	PA		
E8000	NU	EP		GAIT TRAINER, PED SZ, POSTERIOR SUPPORT, INCLUDES ALL ACCESS.	PA	MSRP	
E8000	RR	EP		GAIT TRAINER, PED SZ, POSTERIOR SUPPORT, INCLUDES ALL ACCESS.	PA	MSRP	
E8001	NU	EP		GAIT TRAINER, PED SZ, UPRIGHT SUPPORT, INCLUDES ALL ACCESS.	PA	MSRP	
E8001	RR	EP		GAIT TRAINER, PED SZ, UPRIGHT SUPPORT, INCLUDES ALL ACCESS.	PA	MSRP	
E8002	NU	EP		GAIT TRAINER, PED SZ, ANTERIOR SUPPORT, INCLUDES ALL ACCESSORIES	PA	MSRP	

Procedure Code	Modifiers			Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E8002	RR	EP		GAIT TRAINER, PED SZ, ANTERIOR SUPPORT, INCLUDES ALL ACCESSORIES	PA	MSRP	
K0001	RR	EP		STANDARD WHEELCHAIR	MNF		LIMITED TO A 3 MONTH RENTAL
K0002	RR	EP		STND HEMI (LOW SEAT) WHLCHR	MNF		LIMITED TO A 3 MONTH RENTAL
K0003	RR	EP		LIGHTWEIGHT WHEELCHAIR	MNF		LIMITED TO A 3 MONTH RENTAL
K0004	RR	EP		HIGH STRENGTH LTWT WHLCHR	MNF		LIMITED TO A 3 MONTH RENTAL
K0552	NU	EP		SUP/EXT NON-INS INF PUMP SYR			
K0606	NU	EP		AUTOMATIC DEFIB GARMENT WITH ANALYSIS	PA	IOC	
K0606	RR	EP		AUTOMATIC DEBIC GARMENT WITH ANALYSIS	PA	IOC	
K0607	NU	EP		REPLACEMENT BATTERY FOR AED	MNF		
K0608	NU	EP		REPL GARMENT FOR AED	PA	IOC	
K0609	NU	EP		REPL ELECTRODE FOR AED	PA	IOC	
L0112	NU	EP		CRANIAL CERVICAL ORTHOSIS	PA	IOC	
L0113	NU	EP		CRANIAL CERVICAL ORTHOSIS, TORTICOLLIS TYPE, WITH OR WITHOUT JOINT, WITH OR	PA	IOC	
L0113	RB	EP		CRANIAL CERVICAL ORTHOSIS, TORTICOLLIS TYPE, WITH OR WITHOUT JOINT, WITH OR	CMN	IOC	
L6711	RB	EP		TERMINAL DEVICE, HOOK, MECHANICAL, VOLUNTARY OPENING, ANY MATERIAL, ANY SIZE,	CMN		
L6711	NU	EP		TERMINAL DEVICE, HOOK, MECHANICAL, VOLUNTARY OPENING, ANY MATERIAL, ANY SIZE,	CMN		

Procedure Code	Modifiers			Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L6712	RB	EP		TERMINAL DEVICE, HOOK, MECHANICAL, VOLUNTARY CLOSING, ANY MATERIAL, ANY SIZE,	CMN		
L6712	NU	EP		TERMINAL DEVICE, HOOK, MECHANICAL, VOLUNTARY CLOSING, ANY MATERIAL, ANY SIZE,	CMN		
L8515	NU	EP		GELATIN CAPSULE FOR TRACHEOOESOPHAGEAL VOICE	MNF		
S1002	NU	EP		CUSTOMIZED ITEM-LIST IN ADDITION TO CODE FOR BASICITEM	PA	IOC	
S1015	NU	EP		IV TUBING EXTENSION SET	MNF		
S1040	NU	EP		CRANIAL REMOLDING ORTHOSIS, PEDIATRIC, RIGID, WITH SOFT INTERFACE MATERIAL, CUSTOM FABRICATED, INCLU	PC		
S8189	NU	EP		TRACHEOSTOMY SUPPLY, NOT OTHERWISE CLASSIFIED	1	IOC	1/30
S8265	NU	EP		HABERMAN FEEDER	PA	IOC	
S9001	RR	EP		HOME UTERINE MONITOR	CMN		
S9434	NU	EP	BA	MODIFIED SOLID FOOD SUPPLEMENTS FOR INBORN ERRORS OF METABOL.	CMN	IOC	MUST BE OVER WIC ALLOTMENT
S9434	NU	EP	BO	MODIFIED SOLID FOOD SUPPLEMENTS FOR INBORN ERRORS OF METABOL.	CMN	IOC	MUST BE OVER WIC ALLOTMENT
S9435	NU	EP	BA	METABOLIC FOOD FOR INBORN ERRORS OF METABOL.		IOC	MUST BE OVER WIC ALLOTMENT
S9435	NU	EP	BO	METABOLIC FOOD FOR INBORN ERRORS OF METABOL.		IOC	MUST BE OVER WIC ALLOTMENT
T1999	NU	EP		MISC THERAPEUTIC ITEMS AND SUPPLIES, RETAIL PURCHASE NOC	PA	IOC	
T4521	NU			ADULT SIZE BRIEF/DIAPER SIZE SMALL,EACH	PC		186/30, NON-COVERED FOR

Procedure Code	Modifiers			Description	Reimbursement Guidelines		Limits Qty/Days and Comments
							CHILDREN 3 YEARS AND UNDER
T4521	NU	EP		ADULT SIZE BRIEF/DIAPER SIZE SMALL,EACH	PC		+186/30, NON-COVERED FOR CHILDREN 3 YEARS AND UNDER
T4522	NU			ADULT SIZE BRIEF/DIAPER SIZE MEDIUM, EACH	PC		186/30, NON-COVERED FOR CHILDREN 3 YEARS AND UNDER
T4522	NU	EP		ADULT SIZE BRIEF/DIAPER SIZE MEDIUM, EACH	PC		+186/30, NON-COVERED FOR CHILDREN 3 YEARS AND UNDER
T4523	NU			ADULT SIZE BRIEF/DIAPER SIZE LARGE, EACH	PC		186/30, NON-COVERED FOR CHILDREN 3 YEARS AND UNDER
T4523	NU	EP		ADULT SIZE BRIEF/DIAPER SIZE LARGE, EACH	PC		+186/30, NON-COVERED FOR CHILDREN 3 YEARS AND UNDER
T4524	NU			ADULT SIZE BRIEF/DIAPER SIZE X-LARGE, EACH	PC		186/30, NON-COVERED FOR CHILDREN 3 YEARS AND UNDER
T4524	NU	EP		ADULT SIZE BRIEF/DIAPER SIZE X-LARGE, EACH	PC		+186/30, NON-COVERED FOR CHILDREN 3 YEARS AND UNDER

Procedure Code	Modifiers			Description	Reimbursement Guidelines		Limits Qty/Days and Comments
T4525	NU			ADULT SIZED PROTECTIVE UNDERWEAR, PULL-ON, SMALL	PC		186/30, NON-COVERED FOR CHILDREN 3 YEARS AND UNDER
T4525	NU	EP		ADULT SIZED PROTECTIVE UNDERWEAR, PULL-ON, SMALL	PC		+186/30, NON-COVERED FOR CHILDREN 3 YEARS AND UNDER
T4526	NU			ADULT SIZED PROTECTIVE UNDERWEAR, PULL-ON, MEDIUM	PC		186/30, NON-COVERED FOR CHILDREN 3 YEARS AND UNDER
T4526	NU	EP		ADULT SIZED PROTECTIVE UNDERWEAR, PULL-ON, MEDIUM	PC		+186/30, NON-COVERED FOR CHILDREN 3 YEARS AND UNDER
T4527	NU			ADULT SIZED PROTECTIVE UNDERWEAR, PULL-ON LARGE	PC		186/30, NON-COVERED FOR CHILDREN 3 YEARS AND UNDER
T4527	NU	EP		ADULT SIZED PROTECTIVE UNDERWEAR, PULL-ON LARGE	PC		+186/30, NON-COVERED FOR CHILDREN 3 YEARS AND UNDER
T4528	NU			ADULT SIZED PROTECTIVE UNDERWEAR, PULL-ON, EXTRA LARGE, EACH	PC		186/30, NON-COVERED FOR CHILDREN 3 YEARS AND UNDER
T4528	NU	EP		ADULT SIZED PROTECTIVE UNDERWEAR, PULL-ON, EXTRA LARGE, EACH	PC		+186/30, NON-COVERED FOR

Procedure Code	Modifiers			Description	Reimbursement Guidelines		Limits Qty/Days and Comments
							CHILDREN 3 YEARS AND UNDER
T4529	NU			PEDIATRIC SIZE, BRIEF DIAPER, SMALL/MEDIUM, EACH	PC		186/30, NON-COVERED FOR CHILDREN 3 YEARS AND UNDER
T4529	NU	EP		PEDIATRIC SIZE, BRIEF DIAPER, SMALL/MEDIUM, EACH	PC		+186/30, NON-COVERED FOR CHILDREN 3 YEARS AND UNDER
T4530	NU			PEDIATRIC SIZE, BRIEF DIAPER, LARGE, EACH	PC		186/30, NON-COVERED FOR CHILDREN 3 YEARS AND UNDER
T4530	NU	EP		PEDIATRIC SIZE, BRIEF DIAPER, LARGE, EACH	PC		+186/30, NON-COVERED FOR CHILDREN 3 YEARS AND UNDER
T4531	NU			PEDIATRIC SIZE DISPOSABLE PROTECTIVE UNDERWEAR/PULLON SM/MED	PC		186/30, NON-COVERED FOR CHILDREN 3 YEARS AND UNDER
T4531	NU	EP		PEDIATRIC SIZE DISPOSABLE PROTECTIVE UNDERWEAR/PULLON SM/MED	PC		+186/30, NON-COVERED FOR CHILDREN 3 YEARS AND UNDER
T4532	NU			PEDIATRIC SIZE DISPOSABLE PROTECTIVE UNDERWEAR, PULL/ON LARGE, EACH	PC		186/30, NON-COVERED FOR CHILDREN 3 YEARS AND UNDER

Procedure Code	Modifiers			Description	Reimbursement Guidelines		Limits Qty/Days and Comments
T4532	NU	EP		PEDIATRIC SIZE DISPOSABLE PROTECTIVE UNDERWEAR, PULL/ON LARGE, EACH	PC		+186/30, NON-COVERED FOR CHILDREN 3 YEARS AND UNDER
T4533	NU			YOUTH SIZE DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, EACH	PC		186/30, NON-COVERED FOR CHILDREN 3 YEARS AND UNDER
T4533	NU	EP		YOUTH SIZE DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, EACH	PC		+186/30, NON-COVERED FOR CHILDREN 3 YEARS AND UNDER
T4534	NU			YOUTH SIZE DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, EACH	PC		186/30, NON-COVERED FOR CHILDREN 3 YEARS AND UNDER
T4534	NU	EP		YOUTH SIZE DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, EACH	PC		+186/30, NON-COVERED FOR CHILDREN 3 YEARS AND UNDER
T4537	NU			BED SIZE, PROTECTIVE UNDERPAD, REUSABLE	PC	IOC	4 EVERY 12 MONTHS
T4537	NU	EP		BED SIZE, PROTECTIVE UNDERPAD, REUSABLE	PC	IOC	4 EVERY 12 MONTHS
T4541	NU			DISPOSABLE UNDERPAD, LARGE EACH	PC	IOC	186/30, NON-COVERED FOR CHILDREN 3 YEARS AND UNDER
T4541	NU	EP		DISPOSABLE UNDERPAD, LARGE EACH	PC	IOC	+186/30, NON-COVERED FOR CHILDREN 3 YEARS AND UNDER

Procedure Code	Modifiers			Description	Reimbursement Guidelines		Limits Qty/Days and Comments
T4542	NU			DISPOSABLE UNDERPAD, SMALL, EACH	PC	IOC	186/30, NON-COVERED FOR CHILDREN 3 YEARS AND UNDER
T4542	NU	EP		DISPOSABLE UNDERPAD, SMALL, EACH	PC	IOC	+186/30, NON-COVERED FOR CHILDREN 3 YEARS AND UNDER
T4543	NU			ADULT DISP BRIEF/DIAP ABV XL	PC		186/30, NON-COVERED FOR CHILDREN 3 YEARS AND UNDER
T4543	NU	EP		ADULT DISP BRIEF/DIAP ABV XL	PC		+186/30, NON-COVERED FOR CHILDREN 3 YEARS AND UNDER
T4544	NU			ADLT DISP UND/PULL ON ABV XL	PC		186/30, NON-COVERED FOR CHILDREN 3 YEARS AND UNDER
T4544	NU	EP		ADLT DISP UND/PULL ON ABV XL	PC		+186/30, NON-COVERED FOR CHILDREN 3 YEARS AND UNDER
T5001	NU	EP		POSITIONING SEAT FOR SPECIAL ORTHOPEDIC NEEDS	PA	IOC	
T5999	NU	EP		SUPPLY, NOT OTHERWISE SPECIFIED	PA	IOC	
V5266	NU	EP		BATTERY FOR USE IN HEARING AID DEVICE	MNF		PER PKG OF 4

5.2 Durable Medical Equipment, Includes All Age Participants

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
A4216	NU		STERILE SALINE WATER, 10ML			100/30
A4217	NU		STERILE SALINE WATER, 500ML			30/30
A4230	NU		INFUSION SET FOR EXTERNAL INSULIN PUMP, NON NEEDLE CANNULA TYPE			
A4231	NU		INFUSION SET FOR EXTERNAL INSULIN PUMP, NEEDLE TYPE	MNF		
A4232	NU		SYRINGE WITH NEEDLE FOR EXTERNAL INSULIN PUMP, STERILE, 3CC			
A4247	NU		BETADINE OR IODINE SWABS/WIPES, PER BOX	MNF		
A4310	NU		INSERTION TRAY WITHOUT DRAINAGE BAG AND WITHOUT CATHETER (ACCESSORIES ONLY)	PC		1/30
A4311	NU		INSERTION TRAY WITHOUT DRAINAGE BAG WITH INDWELLING CATHETER, FOLEY TYPE, TWO-WAY LATEX WITH COATING	PC		1/30
A4312	NU		INSERTION TRAY WITHOUT DRAINAGE BAG WITH INDWELLING CATHETER, FOLEY TYPE, TWO-WAY, ALL SILICONE	PC		1/30
A4313	NU		INSERTION TRAY WITHOUT DRAINAGE BAG WITH INDWELLING CATHETER, FOLEY TYPE, THREE-WAY, FOR CONTINUOUS IRR	PC		1/30
A4314	NU		INSERTION TRAY WITH DRAINAGE BAG WITH INDWELLING CATHETER, FOLEY TYPE, TWO-WAY LATEX WITH COATING	PC		1/30
A4315	NU		INSERTION TRAY WITH DRAINAGE BAG WITH INDWELLING CATHETER, FOLEY TYPE, TWO-WAY, ALL SILICONE	PC		1/30
A4316	NU		INSERTION TRAY WITH DRAINAGE BAG WITH INDWELLING CATHETER, FOLEY TYPE, THREE-WAY, FOR CONTINUOUS IRRIG	PC		1/30
A4320	NU		IRRIGATION TRAY WITH BULB OR PISTON SYRINGE, ANY PURPOSE	PC		1/30
A4322	NU		IRRIGATION SYRINGE, BULB OR PISTON, EACH	PC		4/30

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
A4326	NU		MALE EXTERNAL CATHETER	PC		30/30
A4327	NU		FEMALE EXTERNAL URINARY COLLECTION DEVICE; METAL CUP, EACH	PC		1/7
A4328	NU		FEMALE EXTERNAL URINARY COLLECTION DEVICE; POUCH, EACH	PC		1/1
A4331	NU	AU	EXTENSION DRAINAGE TUBING, ANY TYPE, ANY LENGTH, WITH CONNECTOR/ADAPTOR, FOR USE WITH URINARY LEG BAG OR	PC		1/30
A4331	NU		EXTENSION DRAINAGE TUBING, ANY TYPE, ANY LENGTH, WITH CONNECTOR/ADAPTOR, FOR USE WITH URINARY LEG BAG OR	MNF		1/30
A4332	NU		LUBRICANT, INDIVIDUAL STERILE PACKET, FOR INSERTION OF URINARY CATHETER, EACH	PC		30/30
A4333	NU		URINARY CATHETER ANCHORING DEVICE, ADHESIVE SKIN ATTACHMENT, EACH	PC		3/7
A4334	NU		URINARY CATHETER ANCHORING DEVICE, LEG STRAP, EACH	PC		1/30
A4335	NU		INCONTINENCE SUPPLY; MISCELLANEOUS	PC	IOC	
A4338	NU		INDWELLING CATHETER; FOLEY TYPE, TWO-WAY LATEX WITH COATING (TEFLON, SILICONE, SI. ELASTOMER,OR HYDRO), EA	PC		1/30
A4340	NU		INDWELLING CATHETER; SPECIALTY TYPE (E.G.,COUDE, MUSHROOM, WING, ETC.), EACH	PC		1/30
A4344	NU		INDWELLING CATHETER, FOLEY TYPE, TWO-WAY, ALL SILICONE, EACH	PC		1/30
A4346	NU		INDWELLING CATHETER; FOLEY TYPE, THREE WAY FOR CONTINUOUS IRRIGATION, EACH	PC		1/30
A4349	NU		MALE ESTERNAL CATH W/WO ADHESIVE, DISPOSABLE, EACH	PC		30/30
A4351	NU		INTERMITTENT URINARY CATHETER; STRAIGHT TIP, EACH	PC		120/30

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
A4352	NU		INTERMITTENT URINARY CATHETER; COUDE (CURVED) TIP, EACH	PC		120/30
A4353	NU		INTERMITTENT URINARY CATHETER, WITH INSERTION SUPPLIES	PC		120/30
A4354	NU		INSERTION TRAY WITH DRAINAGE BAG BUT WITHOUT CATHETER	PC		1/30
A4355	NU		IRRIGATION TUBING SET FOR CONTINUOUS BLADDER IRRIGATION THROUGH A THREE-WAY INDWELLING FOLEY CATH, EA	PC		
A4356	NU		EXTERNAL URETHRAL CLAMP OR COMPRESSION DEVICE (NOTTO BE USED FOR CATHETER CLAMP), EACH	PC		1/90
A4357	NU	AU	BEDSIDE DRAIN BAG EACH	PC		1/60
A4357	NU		BEDSIDE DRAINAGE BAG, DAY OR NIGHT, WITH OR WITHOUT ANTI-REFLUX DEVICE, WITH OR WITHOUT TUBE, EACH	MNF		2/30
A4358	NU		URINARY LEG BAG; VINYL, WITH OR WITHOUT TUBE, EACH	PC		1/60
A4361	NU		OSTOMY FACEPLATE, EACH	MNF		3/180
A4362	NU		SKIN BARRIER; SOLID, 4X4 OR EQUIVALENT; EACH	MNF		20/30
A4363	NU		OSTOMY CLAMP, ANY TYPE, EACH	MNF		
A4364	NU		ADHESIVE, LIQUID, OR EQUAL ANY TYPE, PER OUNCE ONLY, PER OUNCE	MNF		4/30
A4366	NU		OSTOMY VENT, ANY TYPE, EACH	MNF		10/30
A4367	NU		OSTOMY BELT, EACH	MNF		1/30
A4368	NU		OSTOMY FILTER, ANY TYPE, EACH	MNF		30/30
A4369	NU		OSTOMY SKIN BARRIER, LIQUID (SPRAY, BRUSH, ETC), PER OZ	MNF		2/30
A4371	NU		OSTOMY SKIN BARRIER, POWDER, PER OZ	MNF		10/180

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
A4372	NU		SKIN BARRIER SOLID 4X4 EQUIV	MNF		20/30
A4373	NU		SKIN BARRIER WITH FLANGE	MNF		20/30
A4375	NU		OSTOMY POUCH, DRAINABLE, WITH FACEPLATE ATTACHED PLASTIC, EACH	MNF		2/30
A4376	NU		OSTOMY POUCH, DRAINABLE, WITH FACEPLATE ATTACHED, RUBBER, EACH	MNF		1/30
A4377	NU		OSTOMY POUCH, DRAINABLE, FOR USE ON FACEPLATE, PLASTIC, EACH	MNF		10/30
A4378	NU		OSTOMY POUCH, DRAINABLE, FOR USE ON FACEPLATE, RUBBER, EACH	MNF		4/30
A4379	NU		OSTOMY POUCH, URINARY, WITH FACEPLATE ATTACHED, PLASTIC, EACH	MNF		4/30
A4380	NU		OSTOMY POUCH, URINARY, WITH FACEPLATE ATTACHED, RUBBER, EACH	MNF		4/30
A4381	NU		OSTOMY POUCH, URINARY, FOR USE ON FACEPLATE, PLASTIC, EACH	MNF		10/30
A4382	NU		OSTOMY POUCH, URINARY,FOR USE ON FACEPLATE, HEAVY PLASTIC, EACH	MNF		4/30
A4383	NU		OSTOMY POUCH, URINARY, FOR USE ON FACEPLATE, RUBBER, EACH	MNF		4/30
A4384	NU		OSTOMY FACEPLATE EQUIVALENT, SILICONE RING, EACH	MNF		4/30
A4385	NU		OSTOMY SKIN BARRIER, SOLID 4X4 OR EQUIVALENT, EXTENDED WEAR, WITHOUT BUILT-IN CONVEXITY, EACH	MNF		4/30
A4387	NU		OST POUCH CLOSED, WITH BARRIER,W/BLT IN CONVEXITY 1 PIECE, EACH	MNF		10/30
A4388	NU		DRAINABLE PCH W EX WEAR BARR	MNF		10/30

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
A4389	NU		DRAINABLE PCH W ST WEAR BARR	MNF		10/30
A4390	NU		OSTOMY POUCH, DRAINABLE,WITH EXTENDED WEAR BARRIER ATTACHED, WITH BUILT-IN CONVEXITY (1 PIECE), EACH	MNF		10/30
A4391	NU		OST POUCH, URINARY W/EXTENDED WEAR BARRIER ATTCHD 1 PIECE, EACH	MNF		8/30
A4392	NU		OSTOMY POUCH, URINARY, WITH STANDARD WEAR BARRIER ATTACHED, WITH BUILT-IN CONVEXITY (1 PIECE), EACH	MNF		10/30
A4393	NU		OSTOMY POUCH, URINARY, WITH EXTENDED WEAR BARRIER ATTACHED, WITH BUILT-IN CONVEXITY (1 PIECE), EACH	MNF		10/60
A4396	NU		OSTOMY BELT WITH PERISTOMAL HERNIA SUPPORT	MNF		
A4397	NU		IRRIGATION SUPPLY; SLEEVE, EACH	MNF		4/30
A4398	NU		OSTOMY IRRIGATION SUPPLY; BAG, EACH	MNF		2/180
A4399	NU		OSTOMY IRRIG CONE/CATH W BRS	MNF		1/90
A4402	NU	AU	LUBRICANT, PER OUNCE	PC		8oz/30
A4402	NU		LUBRICANT, PER OUNCE	MNF		4/30
A4404	NU		OSTOMY RING, EACH	MNF		10/30
A4405	NU		NONPECTIN BASED OSTOMY PASTE			4/30
A4406	NU		PECTIN BASED OSTOMY PASTE			4/30
A4407	NU		OST SKIN BARR W/FLANGE SOLID, FLEXIBLE, ACCORDIAN EXTENDED WEAR WITH BLT IN CONVEXITY 4X4 OR SM EACH			10/0
A4408	NU		OST SKN BARR W/FLANGE SOLID, FLEXIBLE,ACCORDIAN EXTWEAR WITH BLT IN CONVEXITY, LARGER THAN 4X4 IN EACH			10/30
A4409	NU		OST SKN BARR W FLNG (SOLID,FLEX OR ACCORDION) EXT WEAR W/OUT BLT IN CONVEX 4X4 IN OR SMALLER EACH			10/30

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
A4410	NU		OST SKN BARR W FLNG (SOLID,FLEX OR ACCORDION) EXT WEAR W/OUT BLT IN CONVEX LARGER THAN 4X4 IN EACH			10/30
A4411	NU		OSTOMY SKIN BARRIER, SOLID 4X4, EXTENDTED WEAR WITH BUILT IN	IOC		10/30
A4412	NU		OSTOMY POUCH, DRAINABLE, FOR USE ON A BARRIER W/FLANGE 2 PIECE	IOC		20/30
A4413	NU		OST POUCH, DRAINABLE, HIGH OUTPUT, FOR USE ON A BARRIER WITH FLANGE (2 PIECE SYSTEM) WITH FILTER, EACH			20/30
A4414	NU		OSTOMY SKNBARR W FLNG SOLID, FLEX, ACCOR WO/CONVEXIT 4X4, EACH			20/30
A4415	NU		OSTOMY SKN BARR W FLNG SOLID, FLEX, ACCOR WO/CONVEXIT LARGER THAN 4X4 INCHES EACH			20/30
A4416	NU		OSTOMY POUCH COSED WBARRIER/FLTR			60/30
A4417	NU		OST POUCH W BAR/BLTINCONV/FLTR			60/30
A4418	NU		OST PCH CLSD W/O BAR W FILTR			60/30
A4419	NU		OST PCH FOR BAR W FLANGE/FLT			60/30
A4420	NU		OST PCH CLSD FOR BAR W IK FL	MNF		60/30
A4421	NU		OSTOMY SUPPLY, MISCELLANEOUS	IOC		
A4422	NU		OST POUCH ABSORBENT MATERIAL, EACH			30/30
A4423	NU		OST PCH FOR BAR W LK FL/FLTR	MNF		60/30
A4424	NU		OST PCH DRAIN W BAR & FILTER			20830
A4425	NU		OST PCH DRAIN FOR BARRIER FL			20/30
A4426	NU		OST PCH DRAIN 2 PIECE SYSTEM			20/30
A4427	NU		OST PCH DRAIN/BARR LK FLNG/F	MNF		20/30

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
A4428	NU		URINE OST POUCH W FAUCE/TAP			20/30
A4429	NU		URINE OST POUCH W BLTIN CONV			20/30
A4430	NU		OST URINE POUCH W B/BLTIN CONV			20/30
A4431	NU		OST PCH URINE W BARRIER/TAPV			20/30
A4432	NU		OST PCH URINE W BAR/FANGE/TAP			20/30
A4433	NU		URINE OST PCH BAR W LOCK FLN			20/30
A4434	NU		OST PCH URINE W LOCK FLNG/FT			20/30
A4435	NU		1PC OST PCH DRAIN HGH OUTPUT	MNF		20/30
A4450	NU		NON-WATERPROOF TAPE, PER 18 SQ. INCHES			40/30
A4452	NU		WATERPROOF TAPE, PER 18 SQ. INCHES			40/30
A4554	NU		DISPOSABLE UNDERPADS, ALL SIZES, (E.G., CHUX'S)	PC	IOC	186/30
A4565	RB		SLINGS	CMN	IOC	
A4565	NU		SLINGS	CMN		
A4604	NU		TUBING WITH INTEGRATED HEATING ELEMENT FOR POSITIVE PRESSURE DEVICE			1/180
A4605	NU		TRACH SUCTION CATHETER, CLOSED	MNF		13/30
A4606	NU		OXYGEN PROBE USED W OXIMETER			1/YEAR
A4618	NU		BREATHING CIRCUITS	MNF		1/180
A4623	NU		TRACH, INNER CANNULA REPLACE	MMF		8/30
A4624	NU		TRACH SUCTION TUBE	MNF		90/30
A4628	NU		OROPHARYNGEAL SUCTION CATHETER, EA	MNF		1/30
A4629	NU		TRACH CARE KIT FOR EST TRACH	MNF		1/1

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
A4635	RB		UNDERARM PAD, CRUTCH, REPLACEMENT, EACH	MNF		
A4636	RB		REPLACEMENT, HANDGRIP, CANE, CRUTCH, OR WALKER, EACH	MNF		
A4637	RB		REPLACEMENT, RIP, CANE, CRUTCH, WALKER, EACH	MNF		
A4640	RB		REPLACEMENT PAD FOR USE W/MEDICALLY NECESSARY ALTERNATING PRESSURE PAD OWNED BY PATIENT	MNF		
A5051	NU		POUCH CLSD W BARR ATTACHED 1 PIECE, EACH	MNF		60/30
A5052	NU		CLSD OSTOMY POUCH W/O BARR 1 PIECE, EACH	MNF		60/30
A5053	NU		CLSD OSTOMY POUCH FACEPLATE EACH	MNF		60/30
A5054	NU		CLSD OSTOMY POUCH W/FLANGE (2 PIECE), EACH	MNF		60/30
A5055	NU		STOMA CAP	MNF		31/30
A5056	NU		1 PC OST POUCH W FILTER	MNF		10/30
A5057	NU		1 PC OST POU W BUILT-IN CONV	MNF		10/30
A5061	NU		POUCH DRAINABLE W BARRIER ATTACHED, EACH	MNF		20/30
A5062	NU		DRNBLE OSTOMY POUCH W/O BARR, EACH	MNF		20/30
A5063	NU		DRAIN OSTOMY POUCH W/FLANGE, EACH	MNF		20/30
A5071	NU		OSTOMY POUCH W/BARRIER, EACH	MNF		20/30
A5072	NU		URINARY POUCH W/O BARRIER, EACH	MNF		20/30
A5073	NU		URINARY POUCH ON BARR W/FLNG, EACH	MNF		20/30
A5081	NU		STOMA PLUG OR SEAL, ANY TYPE	MNF		31/30
A5082	NU		CONTINENT DEVICE; CATHETER FOR CONTINENT STOMA	MNF		2/180
A5083	NU		STOMA ABSORPTIVE COVER	IOC		31/30
A5093	NU		OSTOMY ACCESSORY; CONVEX INSERT	MNF		10/30

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
A5102	NU	AU	BEDSIDE DRAINAGE BOTTLE WITH OR W/O TUBING, RIGID OR EXPANDABLE, EACH	PC		1/90
A5102	NU		BEDSIDE DRAINAGE BOTTLE WITH OR WITHOUT TUBING, RIGID OR EXPANDABLE, EACH	MNF		2/180
A5105	NU		URINARY SUSPENSORY	PC		1/30
A5112	NU		URINARY LEG BAG	PC		1/30
A5113	NU		LEG STRAP; LATEX, REPLACEMENT ONLY, PER SET	MNF		1/30
A5114	NU		LEG STRAP; FOAM OR FABRIC, REPLACEMENT ONLY, PER SET	MNF		18/30
A5120	NU		SKIN BARRIER, WIPES OR SWABS, EACH	MNF		150/180
A5121	NU		SKIN BARRIER; SOLID, 6X6 OR EQUIVALENT, EACH	MNF		20/30
A5122	NU		SKIN BARRIER; SOLID, 8X8 OR EQUIVALENT, EACH	MNF		20/30
A5126	NU		ADHESIVE OR NON-ADHESIVE; DISK OR FOAM PAD	MNF		20/30
A5200	NU		PERCUTANEOUS CATHETER/TUBE ANCHORING DEVICE, ADHESIVE SKIN ATTACHMENT	PC		1/30
A5500	NU		FOR DIABETICS ONLY OFF THE SHELF DEPTH INLAY SHOE MAN TO ACC MULTIDENSITY INSERTS PER SHOE	PC		1 EVERY 12 MONTHS
A5501	NU		DIABETICS ONLY, CUSTOM SHOE MOLDED FROM CAST OF PATIENTS FOOT CUSTOM MOLDED SHOE, PER SHOE	PC		1 EVERY 12 MONTHS
A5503	NU		DIABETICS ONLY, OFF THE SHELF DEPTH INLAY W/ROLLER OR RIGID ROCKER BOTTOM, PER SHOE	PC		
A5504	NU		DIABETICS ONLY, OFF THE SHELF DEPTH INLAY SHOE OR CUSTOM MOLDED WITH WEDGES, PER SHOE	PC		
A5505	NU		DIABETICS ONLY, OFF THE SHELF DEPTH INLAY SHOE OR CUSTOM MOLDED WITH METATARSAL BAR, PER SHOE	PC		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
A5506	NU		DIABETICS ONLY, OFF THE SHELF DEPTH INLAY OR CUSTOM MOLDED WITH OFF-SET HEEL, PER SHOE	PC		
A5507	NU		DIABETICS ONLY, OFF THE SHELF DEPTH INLAY SHOE OR CUSTOM MOLDED SHOE, PER SHOE	PC		
A5512	NU		FOR DIABETICS ONLY, MULTIPLE DENSITY INSERT, DIRECT FORMED, MOLDED TO FOOT	PC		
A5513	NU		FOR DIABETICS ONLY, MULTIPLE DENSITY INSERT, CUSTOM MOLDED FROM MODEL	PC		
A5514	NU		MULTI DENSITY INSERT DIR CARV/CAM	PC		
A6257	NU		TRANSPARENT FILM <= 16 SQ IN			
A7000	NU		CANNISTER, DISPOSABLE	MNF		2/30
A7002	NU		TUBING	MNF		2/30
A7003	NU		ADMINISTRATION SET, WITH SMALL VOLUME NONFILTERED PENUMATIC NEBULIZER, DISPOSABLE	MNF		2/30
A7005	NU		ADMINISTRATION SET, WITH SMALL VOLUME NONFILTERED PENUMATIC NEBULIZER, NON-DISPOSABLE	MNF		1/180
A7013	NU		DISPOSABLE COMPRESSOR FILTER	MNF		2/30
A7027	NU		COMBINATION ORAL/NASAL MASK			1/180
A7028	NU		REPL ORAL CUSHION COMBO MASK			1/180
A7029	NU		REPL NASAL PILLOW COMB MASK			
A7030	NU		CPAP FULL FACE MASK	MNF		1/180
A7031	NU		REPLACEMENT FACEMASK INTERFA	MNF		1/90
A7032	NU		REPLACEMENT CUSHION FOR NASAL APPLICATION DEVICE, EACH	MNF		1/90

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
A7033	NU		REPLACEMENT PILLOWS FOR NASAL APPLICATION DEVICE, PAIR	MNF		1/30
A7034	NU		NASAL INTERFACE(MASK OR CANNULA TYPE) USED WITH POSITIVE AIRWAY PRESSURE DEVICE, W/WO HEAD STRAP	MNF		1/180
A7035	NU		HEADGEAR USED WITH POSITIVE AIRWAY PRESSURE DEVICE	MNF		1/180
A7036	NU		CHINSTRAP USED WITH POSITIVE AIRWAY PRESSURE DEVICE	MNF		1/180
A7037	NU		TUBING USED WITH POSITIVE AIRWAY PRESSURE DEVICE	MNF		1/180
A7038	NU		FILTER, DISPOSABLE USED WITH POSITIVE AIRWAY PRESSURE DEVICE	MNF		
A7039	NU		FILTER, NON DISPOSABLE USED WITH POSITIVE AIRWAY PRESSURE DEVICE	MNF		1/180
A7044	NU		ORAL INTERFACE USED WITH POSITIVE AIRWAY PRESSURE DEVICE, EACH	MNF		1/180
A7045	NU		EXHALATION PORT W/WO SWIVEL USED WITH ACCESS FOR POSITVE AIRWAY DEVICES, REPLACEMENT ONLY	MNF		1/180
A7046	NU		WATER CHAMBER FOR HUMIDIFIER, USED WITH POSITIVE AIRWAY PRESSURE DEVICE, REPLACEMENT, EACH	MNF		
A7520	NU		TRACH/LARYNX TUBE NON-CUFFED	MNF	IOC	2/30
A7521	NU		TRACH/LARYNX TUBE CUFFED	MNF		2/30
A7522	NU		TRACH/LARYNX TUBE STAINLESS			1/30
A7526	NU		TRACH/COLLAR HOLDER, EA	MNF		15/30
A8000	RB		SOFT PROTECT HELMET PREFAB	CMN	IOC	
A8000	NU		SOFT PROTECT HELMET PREFAB	CMN		
A8001	RB		HARD PROTECT HELMET PREFAB	CMN	IOC	
A8001	NU		HARD PROTECT HELMET PREFAB	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
A8002	RB		SOFT PROTECT HELMET CUSTOM	CMN	IOC	
A8002	NU		HELMET, PROTECTIVE, SOFT, CUSTOM FABRICATED, INCLUDES ALL COMPONENTS AND ACCESSORIES	CMN		
A8003	RB		HELMET, PROTECTIVE, HARD, CUSTOM FABRICATED, INCLUDES ALL COMPONENTS AND ACCESSORIES	CMN	IOC	
A8003	NU		HELMET, PROTECTIVE, HARD, CUSTOM FABRICATED, INCLUDES ALL COMPONENTS AND ACCESSORIES	CMN		
A8004	RB		SOFT INTERFACE FOR HELMET, REPLACEMENT ONLY	CMN	IOC	
B4164	NU		PARENTERAL NUTRITION SOLUTION: CARBOHYDRATES(DEXTROSE)50% OR LESS (500ML=1 UNIT) HOME MIX	PC		
B4168	NU		PARENTERAL NUTRITION SOLUTION; AMINO ACID, 3.5%, (500 ML = 1 UNIT) - HOMEMIX	PC		
B4172	NU		PARENTERAL NUTRITION SOLUTION; AMINO ACID, 5.5% THROUGH 7%, (500 ML = 1 UNIT) - HOMEMIX	PC		
B4176	NU		PARENTERAL NUTRITION SOLUTION; AMINO ACID, 7% THROUGH 8.5%, (500 ML = 1 UNIT) - HOMEMIX	PC		
B4178	NU		PARENTERAL NUTRITION SOLUTION: AMINO ACID, GREATER THAN 8.5% (500 ML = 1 UNIT) - HOMEMIX	PC		
B4180	NU		PARENTERAL NUTRITION SOLUTION; CARBOHYDRATES (DEXTROSE), GREATER THAN 50% (500 ML=1 UNIT) - HOMEMIX	PC		
B4185	NU		PARENTERAL NUTRITION SOLUTION, PER 10 GRAMS LIPIDS	PC		
B4189	NU		COM AMINO ACID & CARB WITH ELECT, TRACE ELE & VITA IN PRE ANY STREN, 10 TO 51 GRAMS OF PROTEIN PREMIX	PC		
B4193	NU		COM AMINO ACID & CARB WITH ELECT, TRACE ELE, & VITA IN PRE, ANY STREN, 52 TO 73 GRAMS OF PROTEIN PREMIX	PC		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
B4197	NU		COM AMINO ACID & CARB WITH ELECTR, TRACE ELE & VITA IN PRE, ANY STREN, 74 TO 100 GRAMS OF PROTEIN PREMIX	PC		
B4199	NU		COM AMINO ACID & CARB WITH ELECTR,TRACE ELE & VITA IN PRE, ANY STREN, OVER 100 GRAMS OR PROTEIN PREMIX	PC		
B4216	NU		PARENTERAL NUTRITION; ADDITIVES (VITAMINS, TRACE ELEMENTS, HEPARIN, ELECTROLYTES) HOMEMIX PER DAY	PC		
B4220	NU		PARENTERAL NUTRITION SUPPLY KIT - PREMIX; PER DAY	PC		1 KIT PER DAY
B4222	NU		PARENTERAL NUTRITION SUPPLY KIT - HOMEMIX, PER DAY	PC		1 KIT PER DAY
B4224	NU		PARENTERAL NUTRITION ADMINISTRATION KIT, PER DAY	PC		1 KIT PER DAY
B5000	NU		PARENTERAL SOL RENAL-AMIROSY	PC		
B5100	NU		PARENTERAL SOLUTION HEPATIC	PC		
B5200	NU		PARENTERAL SOL HEPATIC FREAM	PC	IOC	
B9004	RR		PARENTERAL NUTRITION INFUSION PUMP, PORTABLE	PC		RENT TO PURCHASE
B9006	RR		PARENTERAL NUTRITION INFUSION PUMP, STATIONARY	PC		RENT TO PURCHASE
B9999	NU		NOC FOR PARENTERAL SUPPLIES	PC	IOC	
E0100	NU		CANE, INCLUDES CANES OF ALL MATERIALS, ADJUSTABLE OR FIXED, WITH TIP	PC		
E0105	NU		CANE, QUAD OR THREE PRONG, INCLUDES CANES OF ALL MATERIALS, ADJUSTABLE OR FIXED, WITH TIPS	PC		
E0110	NU		CRUTCHES, FOREARM, INCLUDES CRUTCHES OF VARIOUS MATERIALS, ADJUSTABLE OR FIXED, PAIR, COMPLETE WIT	PC		
E0111	NU		CRUTCH FOREARM, INCLUDES CRUTCHES OF VARIOUS MATERIALS, ADJUSTABLE OR FIXED, EACH, WITH TIP AND HA	PC		
E0112	NU		CRUTCHES UNDERARM, WOOD, ADJUSTABLE OR FIXED, PAIR, WITH PADS, TIPS AND HANDGRIPS	PC		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E0113	NU		CRUTCH UNDERARM, WOOD, ADJUSTABLE OR FIXED, EACH, WITH PAD, TIP AND HANDGRIP	PC		
E0114	NU		CRUTCHES UNDERARM, OTHER THAN WOOD, ADJUSTABLE OR FIXED, PAIR, WITH PADS, TIPS AND HANDGRIPS	PC		
E0116	NU		CRUTCH, UNDERARM, OTHER THAN WOOD, ADJUSTABLE OR FIXED, WITH PAD, TIP, HANDGRIP, WITH OR WITHOUT SHO	PC		
E0118	NU		CRUTCH SUBSTITUTE, LOWER LEG PLATFORM WITH OR W/O WHEELS	MNF		
E0130	RR		WALKER, RIGID (PICKUP), ADJUSTABLE OR FIXED HEIGHT	PC		10 MONTH RENT TO PURCHASE
E0130	NU		WALKER, RIGID (PICKUP), ADJUSTABLE OR FIXED HEIGHT	PC		
E0135	RR		WALKER, FOLDING (PICKUP), ADJUSTABLE OR FIXED HEIGHT	PC		10 MONTH RENT TO PURCHASE
E0135	NU		WALKER, FOLDING (PICKUP), ADJUSTABLE OR FIXED HEIGHT	PC		
E0140	RB		WALKER WITH TRUNK SUPPORT ADJUST OR FXD HEIGHT, ANY TYPE	CMN	IOC	
E0140	RR		WALKER WITH TRUNK SUPPORT ADJUST OR FXD HEIGHT, ANY TYPE	PC		10 MONTH RENT TO PURCHASE
E0140	NU		WALKER WITH TRUNK SUPPORT ADJUST OR FXD HEIGHT, ANY TYPE	PC		
E0141	RR		RIGID WHEELED WALKER ADJ/FX	PC		10 MONTH RENT TO PURCHASE
E0141	NU		RIGID WHEELED WALKER ADJ/FX	PC		
E0143	RR		WALKER FOLDING WHEELED W/O S	PC		10 MONTH RENT TO PURCHASE
E0143	NU		WALKER FOLDING WHEELED W/O S	PC		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E0147	RR		WALKER VARIABLE WHEEL RESIST	PC		10 MONTH RENT TO PURCHASE
E0147	NU		WALKER VARIABLE WHEEL RESIST	PC		
E0148	RR		WALKER, HEAVY DUTY, WITHOUT WHEELS, RIGID OR FOLDING, ANY TYPE, EACH	PC		10 MONTH RENT TO PURCHASE
E0148	NU		WALKER, HEAVY DUTY, WITHOUT WHEELS, RIGID OR FOLDING, ANY TYPE, EACH	PC		
E0149	RR		HEAVY DUTY WHEELED WALKER	PC		10 MONTH RENT TO PURCHASE
E0149	NU		HEAVY DUTY WHEELED WALKER	PC		
E0153	RR		PLATFORM ATTACHMENT, FOREARM CRUTCH, EACH	MNF		
E0153	NU		PLATFORM ATTACHMENT, FOREARM CRUTCH, EACH	MNF		
E0154	RR		PLATFORM ATTACHMENT, WALKER, EACH	MNF		
E0154	NU		PLATFORM ATTACHMENT, WALKER, EACH	MNF		
E0155	NU		WHEEL ATTACHMENT, RIGID PICK-UP WALKER, PER PAIR	MNF		
E0156	NU		SEAT ATTACHMENT, WALKER	MNF		
E0157	RR		CRUTCH ATTACHMENT, WALKER, EACH	MNF		
E0157	NU		CRUTCH ATTACHMENT, WALKER, EACH	MNF		
E0158	NU		LEG EXTENSIONS FOR A WALKER, PER SET OF FOUR (4)	MNF		
E0159	NU		BRAKE ATTACHMENT FOR WHEELED WALKER, REPLACEMENT, EACH	MNF		
E0163	NU		COMMODE CHAIR, MOBILE OR STATIONARY, WITH FIXED ARMS	PC		
E0165	NU		COMMODE CHAIR, MOBILE OR STATIONARY, WITH DETACHABLE ARMS	PC		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E0167	RB		PAIL OR PAN FOR USE WITH COMMODE CHAIR, REPLACEMENT ONLY	MNF		
E0168	NU		COMMODE CHAIR, EXTRA WIDE AND/OR HEAVY DUTY, STATIONARY OR MOBILE, WITH OR WITHOUT ARMS, ANY TYPE	PC		
E0175	RR		FOOT REST, FOR USE WITH COMMODE CHAIR, EACH	MNF		
E0175	NU		FOOT REST, FOR USE WITH COMMODE CHAIR, EACH	MNF		
E0181	RB		PRESSURE PAD, ALTERNATING WITH PUMP	CMN	IOC	
E0181	RR		PRESSURE PAD, ALTERNATING WITH PUMP	PC		10 MONTH RENT TO PURCHASE
E0181	NU		PRESSURE PAD, ALTERNATING WITH PUMP	PC		
E0182	RR		PUMP FOR ALTERNATING PRESSURE PAD	MNF		
E0182	NU		PUMP FOR ALTERNATING PRESSURE PAD	MNF		
E0182	RB		PUMP FOR ALTERNATING PRESSURE PAD	CMN		
E0184	NU		DRY PRESSURE MATTRESS	PC		
E0185	RR		DECUBITUS CARE PAD, FLOTATION OR GEL PAD WITH FOAM LEVELING PAD (MATTRESS SIZE)	PC		10 MONTH RENT TO PURCHASE
E0185	NU		GEL OR GEL-LIKE PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH	PC		
E0186	NU		AIR PRESSURE MATTRESS	PC		
E0187	NU		WATER PRESSURE MATTRESS	PC		
E0190	NU		POSITIONING CUSHION/PILLOW/WEDGE, ANY SHAPE OR SIZE, INCLUDES ALL COMPONENTS AND ACCESSORIES	CMN	IOC	
E0196	NU		GEL PRESSURE MATTRESS	PC		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E0197	RR		AIR PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH	PC		10 MONTH RENT TO PURCHASE E
E0197	NU		AIR PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH	PC		
E0217	NU		WATER CIRCULATING HEAT PAD WITH PUMP	MNF		
E0218	NU		WATER CIRCULATING COLD PAD WITH PUMP	MNF		
E0250	RB		HOSPITAL BED, WITH SIDE RAILS, FIXED HEIGHT, WITH MATTRESS	CMN	IOC	
E0250	RR		HOSPITAL BED, WITH SIDE RAILS, FIXED HEIGHT, WITH MATTRESS	PC		12 MONTH RENT TO PURCHASE
E0250	NU		HOSPITAL BED, WITH SIDE RAILS, FIXED HEIGHT, WITH MATTRESS	PC		
E0251	RB		HOSPITAL BED, WITH SIDE RAILS, FIXED HEIGHT, WITHOUT MATTRESS	CMN	IOC	
E0251	RR		HOSPITAL BED, WITH SIDE RAILS, FIXED HEIGHT, WITHOUT MATTRESS	PC		12 MONTH RENT TO PURCHASE
E0251	NU		HOSPITAL BED, WITH SIDE RAILS, FIXED HEIGHT, WITHOUT MATTRESS	PC		
E0255	RB		HOSPITAL BED, WITH SIDE RAILS VARIABLE HEIGHT, HI-LO, WITH MATTRESS	CMN		
E0255	RR		HOSPITAL BED, WITH SIDE RAILS VARIABLE HEIGHT, HI-LO, WITH MATTRESS	PC		12 MONTH RENT TO PURCHASE
E0255	NU		HOSPITAL BED, WITH SIDE RAILS VARIABLE HEIGHT, HI-LO, WITH MATTRESS	PC		
E0256	RR		HOSP BED, VARIABLE HGHT, HI/LO, WITH ANY TYPE SIDERAILS WITHOUT MATTRESS	PC		12 MONTH RENT TO PURCHASE

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E0256	NU		HOSPITAL BED, VARIABLE HEIGHT,HI-LO, WITH ANY TYPESIDE RAILS, WITHOUT MATTRESS	PC		
E0260	RB		HOSPITAL BED, WITH SIDE RAILS, SEMI-ELECTRIC, HEAD AND FOOT ADJUSTMENT, WITH MATTRESS	CMN	IOC	
E0260	RR		HOSPITAL BED, WITH SIDE RAILS, SEMI-ELECTRIC, HEAD AND FOOT ADJUSTMENT, WITH MATTRESS	PC		22 MONTH RENT TO PURCHASE
E0261	RR		HOSP BED, SEMI ELECT WITH ANY TYPE SIDE RAILS WITHOUT MATTRESS.	PC		12 MONTH RENT TO PURCHASE
E0261	NU		HOSPITAL BED, SEMIELECTRIC (HEAD AND FOOT ADJUSTMENT), WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS	PC		
E0271	NU		MATTRESS, INNERSPRING	CMN		
E0271	RR		MATTRESS, INNERSPRING	CMN 1st claim only		
E0272	NU		MATTRESS, FOAM RUBBER	CMN		
E0272	RR		MATTRESS, FOAM RUBBER	CMN 1st claim only		
E0275	NU		BED PAN, STANDARD METAL OR PLASTIC	PC		
E0276	NU		BED PAN, FRACTURE METAL OR PLASTIC	PC		
E0290	RB		HOSPITAL BED, FIXED HEIGHT, WITHOUT SIDE RAILS, WITH MATTRESS	CMN	IOC	
E0290	RR		HOSPITAL BED, FIXED HEIGHT, WITHOUT SIDE RAILS, WITH MATTRESS	PC		12 MONTH RENT TO PURCHASE
E0290	NU		HOPSITAL BED, FIXED HEIGHT, WITHOUT SIDE RAILS, WITH MATTRESS	PC		
E0291	RR		HOSPITAL BED, FXD HGHT, W/O SIDERAILS W/O MATTRESS	PC		12 MONTH RENT TO PURCHASE

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E0291	NU		HOSPITAL BED, FIXED HEIGHT, WITHOUT SIDE RAILS,WITHOUT MATTRESS	PC		
E0292	RR		HOSP BED VAR HT NO SR W/MATT	PC		12 MONTH RENT TO PURCHASE
E0292	NU		HOSP BED VAR HT NO SR W/MATT	PC		
E0293	RR		HOSP BED VAR HT NO SR NO MAT	PC		
E0293	NU		HOSP BED VAR HT NO SR NO MAT	PC		
E0294	RR		HOSPITAL BED, SEMI ELECTRIC, WITHOUT SIDERAILS, W/MATTRESS	PC		12 MONTH RENT TO PURCHASE
E0294	NU		HOSPITAL BED, SEMIELECTRIC (HEAD AND FOOT ADJUSTMENT), WITHOUT SIDE RAILS, WITH MATTRESS	PC		
E0295	RR		HOSP BED, SEMI ELECTRIC, W/O SIDERAILS WITHOUT MATTRESS	PC		12 MONTH RENT TO PURCHASE
E0295	NU		HOSPITAL BED, SEMIELECTRIC (HEAD AND FOOT ADJUSTMENT), WITHOUT SIDE RAILS, WITHOUT MATTRESS	PC		
E0305	RR		BED SIDE RAILS, HALF LENGTH	CMN		
E0305	NU		BED SIDE RAILS, HALF LENGTH	CMN		
E0310	RR		BED SIDE RAILS, FULL LENGTH	CMN		
E0310	NU		BED SIDE RAILS, FULL LENGTH	CMN		
E0325	NU		URINAL MALE JUG TYPE ANY MATERIAL	PC		
E0326	NU		URINAL FEMALE, JUG TYPE, ANY MATERIAL	PC		
E0424	RR		STATIONARY COMPRESSED GASEOUS OXYGEN SYSTEM, RENTAL	PC		CONTINUOUS RENTAL
E0424	RR	QF	STATIONARY COMPRESSED GASEOUS OXYGEN SYSTEM, RENTAL; > 4 LPM W/ PORTABLE OXYGEN PRESCRIBED	PC		CONTINUOUS RENTAL

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E0424	RR	QG	STATIONARY COMPRESSED GASEOUS OXYGEN SYSTEM, RENTAL; > 4 LPM	PC		CONTINUOUS RENTAL
E0431	RR		PORTABLE GAS OXYGEN SYSTEM RENTAL	PC		CONTINUOUS RENTAL
E0434	RR		PORTABLE LIQUID OXYGEN SYSTEM RENTAL	PC		CONTINUOUS RENTAL
E0439	RR		STATIONARY LIQUID SYSTEM, RENTAL	PC		CONTINUOUS RENTAL
E0439	RR	QF	STATIONARY LIQUID SYSTEM, RENTAL > 4 LPM & PORTABLE OXYGEN IS PRESCRIBED	PC		CONTINUOUS RENTAL
E0439	RR	QG	STATIONARY LIQUID SYSTEM, RENTAL >4 LPM	PC		CONTINUOUS RENTAL
E0441	NU		STATIONARY O2 CONTENTS, GAS	PC		ONE MONTH SUPPLY = ONE UNIT
E0442	NU		STATIONARY O2 CONTENTS, LIQ	PC		ONE MONTH SUPPLY = ONE UNIT
E0443	NU		PORTABLE 02 CONTENTS, GAS	PC		ONE MONTH SUPPLY = ONE UNIT 1/30
E0444	NU		PORTABLE 02 CONTENTS, LIQUID	PC		ONE MONTH SUPPLY = ONE UNIT 1/30
E0465	RR	TW	HOME VENT INVASIVE INTERFACE	PC		BACK UP FOR VOL VENT
E0465	RR		HOME VENT INVASIVE INTERFACE	PC		
E0466	RR	TW	HOME VENT NON-INVASIVE INTERFACE	PA		
E0466	RR		HOME VENT NON-INVASIVE INTERFACE	PA		
E0470	RB		RAD W/O BACKUP NON-INV INTFC	CMN	IOC	
E0470	RR		RAD W/O BACKUP NON-INV INTFC	PC		MONTHS 1-3, RENT TO PURCHASE

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E0470	RR	KJ	RAD W/O BACKUP NON-INV INTFC	PC		MONTHS 4-22, RENT TO PURCHASE
E0471	RB		RAD W/BACKUP NON-INV INTFC	CMN	IOC	
E0471	RR		RAD W/BACKUP NON INV INTRFC	PC		MONTHS 1-3, RENT TO PURCHASE
E0471	RR	KJ	RAD W/BACKUP NON INV INTRFC	PC		MONTHS 4-22, RENT TO PURCHASE
E0500	RR		IPPB MACHINE W/MANUAL VALVES EXTERNAL POWER SOURCEINCLUDES CYLINDER REGULATOR, BUILT-IN NEBULIZATION	MNF		
E0500	NU		IPPB MACHINE W/MANUAL VALVES EXTERNAL POWER SOURCEINCLUDES CYLINDER REGULATOR, BUILT-IN NEBULIZATION	MNF		
E0500	RB		IPPB MACHINE W/MANUAL VALVES EXTERNAL POWER SOURCEINCLUDES CYLINDER REGULATOR, BUILT-IN NEBULIZATION	CMN	IOC	
E0550	RB		HUMIDIFIER, DURABLE FOR EXTENSIVE SUPPLEMENTAL HUMIDIFICATION DURING IPPB TREATMENTS OR OXYGEN DELIV	CMN	IOC	
E0550	NU		HUMIDIFIER, DURABLE FOR EXTENSIVE SUPPLEMENTAL HUMIDIFICATION DURING IPPB TREATMENTS OR OXYGEN DELIV	CMN		
E0550	RR		HUMIDIFIER, DURABLE FOR EXTENSIVE SUPPLEMENTAL HUMIDIFICATION DURING IPPB TREATMENTS OR OXYGEN DELIV	CMN 1st claim only		
E0561	NU		HUMIDIFIER, NON-HEATED, USED WITH POSITIVE AIRWAY PRESSURE DEVICE	PC		
E0561	RB		HUMIDIFIER, NON-HEATED, USED WITH POSITIVE AIRWAY PRESSURE DEVICE	CMN	IOC	
E0562	NU		HUMIDIFIER, HEATED, USED WITH POSITIVE AIRWAY PRESSURE	PC		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E0562	RB		HUMIDIFIER, HEATED, USED WITH POSITIVE AIRWAY PRESSURE	CMN	IOC	
E0565	RR		COMPRESSOR, AIR POWER SOURCE FOR EQUIPMENT WHICH IS NOT SELF-CONTAINED OR CYLINDER DRIVEN	PC		RENTAL ONLY
E0570	RR		NEBULIZER, WITH COMPRESSOR E.G., DEVILBISS PULMO-AID	PC		
E0570	RB		NEBULIZER, WITH COMPRESSOR E.G., DEVILBISS PULMO-AID	CMN		
E0570	NU		NEBULIZER, WITH COMPRESSOR E.G., DEVILBISS PULMO-AID	PC		
E0575	RR		NEBULIZER, SELF-CONTAINED, ULTRASONIC	MNF		
E0575	NU		NEBULIZER, SELF-CONTAINED, ULTRASONIC	MNF		
E0575	RB		NEBULIZER, SELF-CONTAINED, ULTRASONIC	CMN	IOC	
E0585	RB		NEBULIZER, WITH COMPRESSOR AND HEATER	CMN	IOC	
E0585	RR		NEBULIZER, WITH COMPRESSOR AND HEATER	PC		
E0585	NU		NEBULIZER, WITH COMPRESSOR AND HEATER	PC		
E0600	RB		SUCTION PUMP, HOME MODEL, PORTABLE	CMN	IOC	
E0600	RR		SUCTION PUMP, HOME MODEL, PORTABLE	PC		
E0600	NU		SUCTION PUMP, HOME MODEL, PORTABLE	PC		
E0601	RB		CONT AIRWAY PRESSURE DEVICE	CMN	IOC	
E0601	RR		CONT AIRWAY PRESSURE DEVICE	PC		MONTHS 1-3, RENT TO PURCHASE
E0601	RR	KJ	CONT AIRWAY PRESSURE DEVICE	PC		MONTHS 4-24, RENT TO PURCHASE
E0619	RR		APNEA MONITOR W RECORDER	PC		MONTHS 1-4
E0619	RR	KJ	APNEA MONITOR W RECORDER MONTHS 5-12	PC		MONTHS 5-12
E0621	NU		SLING OR SEAT, PATIENT LIFT, CANVAS OR NYLON	MNF		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E0630	RB		PATIENT LIFT HYDRAULIC	CMN	IOC	
E0630	RR		PATIENT LIFT HYDRAULIC	PC		15 MONTH RENT TO PURCHASE
E0705	NU		TRANSFER DEVICE	CMN		
E0705	NU	SC	TRANSFER BOARD OR DEVICE, ANY TYPE, EACH	PA		
E0760	NU		OSTOGENESIS STIMULATOR, LOW INTENSITY ULTRASOUND, NON-INVASIVE	PC		
E0784	RR		EXTERNAL AMBULATORY INFUSION PUMP, INSULIN	PC		12 MONTH RENT TO PURCHASE
E0784	NU		EXTERNAL AMBULATORY INFUSION PUMP, INSULIN	PC		
E0910	RR		TRAPEZE BARS AKA PATIENT HELPER, ATTACHED TO BED, WITH GRAB BAR	MNF		
E0910	NU		TRAPEZE BARS AKA PATIENT HELPER, ATTACHED TO BED, WITH GRAB BAR	MNF		
E0910	RB		TRAPEZE BARS AKA PATIENT HELPER, ATTACHED TO BED, WITH GRAB BAR	CMN	IOC	
E0940	RR		TRAPEZE BAR, FREE STANDING, COMPLETE WITH GRAB BAR	MNF		
E0940	NU		TRAPEZE BAR, FREE STANDING, COMPLETE WITH GRAB BAR	MNF		
E0940	RB		TRAPEZE BAR, FREE STANDING, COMPLETE WITH GRAB BAR	CMN	IOC	
E0950	RB		TRAY	CMN		
E0950	RB	SC	TRAY	CMN		
E0950	NU		TRAY	CMN		
E0950	NU	SC	TRAY	PA		
E0951	RB		HEEL LOOP/HOLDER ANY TYPE WITH/WO ANKLE STRAP, EACH	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E0951	RB	SC	HEEL LOOP/HOLDER ANY TYPE WITH/WO ANKLE STRAP, EACH	CMN		
E0951	NU		HEEL LOOP/HOLDER, ANY TYPE WITH/WO ANKLE STRAP, EACH	CMN		
E0951	NU	SC	HEEL LOOP/HOLDER ANY TYPE WITH/WO ANKLE STRAP, EACH	PA		
E0952	RB		TOE LOOP/HOLDER, ANY TYPE, EACH	CMN		
E0952	RB	SC	TOE LOOP/HOLDER, ANY TYPE, EACH	CMN		
E0952	NU		TOE LOOP/HOLDER, ANY TYPE, EACH	CMN		
E0952	NU	SC	TOE LOOP/HOLDER, ANY TYPE, EACH	PA		
E0953	NU		W/C LATERAL THIGH/KNEE SUP	CMN		
E0953	NU	SC	W/C LATERAL THIGH/KNEE SUP	PA		
E0953	RB		W/C LATERAL THIGH/KNEE SUP	CMN		
E0953	RB	SC	W/C LATERAL THIGH/KNEE SUP	CMN		
E0954	NU		FOOT BOX, ANY TYPE, EACH FOOT	CMN		
E0954	NU	SC	FOOT BOX, ANY TYPE, EACH FOOT	PA		
E0954	RB		FOOT BOX, ANY TYPE, EACH FOOT	CMN		
E0954	RB	SC	FOOT BOX, ANY TYPE, EACH FOOT	CMN		
E0955	RB		HEADREST CUSHIONED ANY TYPE INCLUDING FXD MNTG, WHEELCHAIR ACCESS	CMN		
E0955	RB	SC	HEADREST CUSHIONED ANY TYPE INCLUDING FXD MNTG, WHEELCHAIR ACCESS	CMN		
E0955	NU		HEADREST, CUSHIONED ANY TYPE INCLUDING FXD MNTG, WHEELCHAIR ACCESS	CMN		
E0955	NU	SC	HEADREST CUSHIONED ANY TYPE INCLUDING FXD MNTG, WHEELCHAIR ACCESS	PA		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E0956	RB		LATERAL TRUNK OR HIP SUPPORT W/C ACCESS	CMN		
E0956	RB	SC	LATERAL TRUN OR HIP SUPPORT W/C ACCESS	CMN		
E0956	NU		LATERAL TRUNK OR HIP SUPPORT, W/C ACCESS	CMN		
E0956	NU	SC	LATERAL TRUN OR HIP SUPPORT, W/C ACCESS	PA		
E0957	RB		MEDIAL THIGH SUPPORT ANY TYPE INCLUDING FSD MNTG W/C ACCESS	CMN		
E0957	RB	SC	MEDIAL THIGH SUPPORT ANY TYPE INCLUDING FSD MNTG W/C ACCESS	CMN		
E0957	NU		MEDIAL THIGH SUPPORT, ANY TYPED INCLUDING FSD MNTG, W/C ACCESS	CMN		
E0957	NU	SC	MEDIAL THIGH SUPPORT ANY TYPE INCLUDING FSD MNTG W/C ACCESS	PA		
E0958	RR	SC	WHEELCHAIR ATTACHMENT TO CONVERT ANY WHEELCHAIR TO ONE ARM DRIVE	CMN		
E0958	RB		WHEELCHAIR ATTACHMENT TO CONVERT ANY WHEELCHAIR TO ONE ARM DRIVE	CMN		
E0958	RB	SC	WHEELCHAIR ATTACHMENT TO CONVERT ANY WHEELCHAIR TO ONE ARM DRIVE	CMN		
E0958	NU		WHEELCHAIR ATTACHMENT TO CONVERT ANY WHEELCHAIR TO ONE ARM DRIVE	CMN		
E0958	NU	SC	WHEELCHAIR ATTACHMENT TO CONVERT ANY WHEELCHAIR TO ONE ARM DRIVE	PA		
E0958	RR		WHEELCHAIR ATTACHMENT TO CONVERT ANY WHEELCHAIR TO ONE ARM DRIVE	CMN 1st claim only		
E0959	RB		MANUAL WHEELCHAIR ACCESSORY, ADAPTER FOR AMPUTEE, EACH	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E0959	RB	SC	MANUAL WHEELCHAIR ACCESSORY, ADAPTER FOR AMPUTEE, EACH	CMN		
E0959	NU		MANUAL WHEELCHAIR ACCESSORY, ADAPTER FOR AMPUTEE, EACH	CMN		
E0959	RR	SC	MANUAL WHEELCHAIR ACCESSORY, ADAPTER FOR AMPUTEE, EACH	PA		
E0959	NU	SC	MANUAL WHEELCHAIR ACCESSORY, ADAPTER FOR AMPUTEE, EACH	PA		
E0959	RR		MANUAL WHEELCHAIR ACCESSORY, ADAPTER FOR AMPUTEE, EACH	CMN 1st claim only		
E0960	RB		W/C SHOULDER HARNESS/STRAP	CMN		
E0960	RB	SC	W/C SHOULDER HARNESS/STRAP	CMN		
E0960	NU		W/C SHOULDER HARNESS/STRAP	CMN		
E0960	NU	SC	W/C SHOULDER HARNESS/STRAP	PA		
E0961	RB		BRAKE EXTENSION, FOR WHEELCHAIR	CMN		
E0961	RB	SC	BRAKE EXTENSION, FOR WHEELCHAIR	CMN		
E0961	NU		BRAKE EXTENSION, FOR WHEELCHAIR	CMN		
E0961	NU	SC	BRAKE EXTENSION, FOR WHEELCHAIR	PA		
E0966	RB		HOOK ON HEAD REST EXTENSION	CMN		
E0966	RB	SC	HOOK ON HEAD REST EXTENSION	CMN		
E0966	NU		HOOK ON HEAD REST EXTENSION	CMN		
E0966	RR	SC	HOOK ON HEAD REST EXTENSION	PA		
E0966	NU	SC	HOOK ON HEAD REST EXTENSION	PA		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E0966	RR		HOOK ON HEAD REST EXTENSION	CMN 1st claim only		
E0967	NU		MAN WC RIM/PROJECTION REP EA	CMN		
E0967	RB		MAN WC RIM/PROJECTION REP EA	CMN		
E0967	RB	SC	MAN WC RIM/PROJECTION REP EA	CMN		
E0967	NU	SC	MAN WC RIM/PROJECTION REP EA	PA		
E0968	RR		COMMODE SEAT, WHEELCHAIR	CMN		
E0968	RB		COMMODE SEAT, WHEELCHAIR	CMN		
E0968	RB	SC	COMMODE SEAT, WHEELCHAIR	CMN		
E0968	NU		COMMODE SEAT, WHEELCHAIR	CMN		
E0968	RR	SC	COMMODE SEAT, WHEELCHAIR	PA		
E0968	NU	SC	COMMODE SEAT, WHEELCHAIR	PA		
E0969	RB		WHEELCHAIR NARROWING DEVICE	CMN		
E0969	RB	SC	WHEELCHAIR NARROWING DEVICE	CMN		
E0969	NU		WHEELCHAIR NARROWING DEVICE	CMN		
E0969	NU	SC	WHEELCHAIR NARROWING DEVICE	PA		
E0970	RB		NO. 2 FOOTPLATES EXCEPT FOR ELEVATING LEG REST	CMN		
E0970	RB	SC	NO. 2 FOOTPLATES EXCEPT FOR ELEVATING LEG REST	CMN		
E0970	NU		NO.2 FOOTPLATES, EXCEPT FOR ELEVATING LEG REST	CMN		
E0970	NU	SC	NO. 2 FOOTPLATES EXCEPT FOR ELEVATING LEG REST	PA		
E0971	RB		ANTI-TIPPING DEVICE, WHEELCHAIRS	CMN		
E0971	RB	SC	ANTI-TIPPING DEVICE, WHEELCHAIRS	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E0971	NU		WHEELCHAIR ACCESS., ANTI TIPPING DEVICE, EACH	CMN		
E0971	NU	SC	ANTI-TIPPING DEVICE, WHEELCHAIRS	PA		
E0973	RB		ADJUSTABLE HEIGHT DETACHABLE ARMS DESK OR FULL LENGTH WHEELCHAIR	CMN		
E0973	RB	SC	ADJUSTABLE HEIGHT DETACHABLE ARMS DESK OR FULL LENGTH WHEELCHAIR	CMN		
E0973	NU		ADJUSTABLE HEIGHT DETACHABLE ARMS,DESK OR FULL LENGTH, WHEELCHAIR	CMN		
E0973	RR	SC	ADJUSTABLE HEIGHT DETACHABLE ARMS DESK OR FULL LENGTH WHEELCHAIR	PA		
E0973	NU	SC	ADJUSTABLE HEIGHT DETACHABLE ARMS DESK OR FULL LENGTH WHEELCHAIR	PA		
E0973	RR		ADJUSTABLE HEIGHT DETACHABLE ARMS, DESK OR FULL LENGTH, WHEELCHAIR	CMN 1st claim only		
E0974	RB		GRADE-AID (DEVICE TO PREVENT ROLLING BACK ON AN INCLINE) FOR WHEELCHAIR	CMN		
E0974	RB	SC	GRADE-AID (DEVICE TO PREVENT ROLLING BACK ON AN INCLINE) FOR WHEELCHAIR	CMN		
E0974	NU		GRADE-AID (DEVICE TO PREVENT ROLLING BACK ON AN INCLINE) FOR WHEELCHAIR	CMN		
E0974	NU	SC	GRADE-AID (DEVICE TO PREVENT ROLLING BACK ON AN INCLINE) FOR WHEELCHAIR	PA		
E0978	NU		POSITIONING BELT/SAFETY BELT/PELVIC STRAP EACH, W/C ACCESS	CMN		
E0978	RB		POSITIONING BELT/SAFETY BELT/PELVIC STRAP EACH W/C ACCESS	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E0978	RB	SC	POSITIONING BELT/SAFETY BELT/PELVIC STRAP EACH W/C ACCESS	CMN		
E0978	NU	SC	POSITIONING BEL/SAFETY BELT/PELVIC STRAP EACH W/C ACCESS	PA		
E0980	RB		SAFETY VEST, WHEELCHAIR	CMN		
E0980	RB	SC	SAFETY VEST, WHEELCHAIR	CMN		
E0980	NU		SAFETY VEST, WHEELCHAIR	CMN		
E0980	NU	SC	SAFETY VEST, WHEELCHAIR	PA		
E0981	RB		SEAT UPHOLSTERY, REPLACEMENT	CMN		
E0981	RB	SC	SEAT UPHOLSTERY, REPLACEMENT	CMN		
E0982	RB		BACK UPHOLSTERY, REPLACEMENT	CMN		
E0982	RB	SC	BACK UPHOLSTERY, REPLACEMENT	CMN		
E0983	RB		ADD POWER JOYSTICK	PA		
E0983	RB	SC	ADD POWER JOYSTICK	PA		
E0983	NU		ADD POWER JOYSTICK	PA		
E0983	NU	SC	ADD POWER JOYSTICK	PA		
E0984	RB		ADD POWER TILLER	CMN		
E0984	RB	SC	ADD POWER TILLER	CMN		
E0984	NU		ADD POWER TILLER	PA		
E0984	NU	SC	ADD POWER TILLER	PA		
E0986	RB		MAN W/C PUSH-RIM POWR SYSTEM	PA		
E0986	RR		MAN W/C PUSH-RIM POWR SYSTEM	PA		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E0988	RB		LEVER-ACTIVATED WHEEL DRIVE	CMN		
E0988	RB	SC	LEVER-ACTIVATED WHEEL DRIVE	CMN		
E0988	RR		LEVER-ACTIVATED WHEEL DRIVE	PA		
E0988	RR	SC	LEVER-ACTIVATED WHEEL DRIVE	PA		
E0988	NU		LEVER-ACTIVATED WHEEL DRIVE	PA		
E0988	NU	SC	LEVER-ACTIVATED WHEEL DRIVE	PA		
E0990	RB	SC	ELEVATING LEG REST, EACH	CMN		
E0990	RB		ELEVATING LEG REST, EACH	CMN		
E0990	NU		ELEVATING LEG REST, EACH	CMN		
E0990	NU	SC	ELEVATING LEG REST, EACH	PA		
E0992	RB		SOLID SEAT INSERT	CMN		
E0992	RB	SC	SOLID SEAT INSERT	CMN		
E0992	NU		SOLID SEAT INSERT	CMN		
E0992	NU	SC	SOLID SEAT INSERT	PA		
E0994	RB		ARM REST, EACH	CMN		
E0994	RB	SC	ARM REST, EACH	CMN		
E0994	NU		ARM REST, EACH	CMN		
E0994	NU	SC	ARM REST, EACH	PA		
E0995	RB		WC CALF REST, PAD REPLACEMNT	CMN		
E0995	RB	SC	WC CALF REST, PAD REPLACEMNT	CMN		
E0995	NU		WC CALF REST, PAD REPLACEMNT	CMN		
E1002	RB		PWR SEAT TILT	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E1002	RB	SC	PWR SEAT TILT	CMN		
E1002	NU		PWR SEAT TILT	PA		
E1002	NU	SC	PWR SEAT TILT	PA		
E1003	RB		PWR SEAT RECLINE	CMN		
E1003	RB	SC	PWR SEAT RECLINE	CMN		
E1003	NU		PWR SEAT RECLINE	PA		
E1003	NU	SC	PWR SEAT RECLINE	PA		
E1004	RB		PWR SEAT RECLINE MECH	CMN		
E1004	RB	SC	PWR SEAT RECLINE MECH	CMN		
E1004	NU		PWR SEAT RECLINE MECH	PA		
E1004	NU	SC	PWR SEAT RECLINE MECH	PA		
E1005	RB		PWR SEAT RECLINE PWR	CMN		
E1005	RB	SC	PWR SEAT RECLINE	CMN		
E1005	NU		PWR SEAT RECLINE PWR	PA		
E1005	NU	SC	PWR SEAT RECLINE	PA		
E1006	RB		PWR SEAT COMBO W/O SHEAR	CMN		
E1006	RB	SC	PWR SEAT COMBO W/O SHEAR	CMN		
E1006	NU		PWR SEAT COMBO W/O SHEAR	PA		
E1006	NU	SC	PWR SEAT COMBO W/O SHEAR	PA		
E1007	RB		PWR SEAT COMBO W/SHEAR	CMN		
E1007	RB	SC	PWR SEAT COMBO W/SHEAR	CMN		
E1007	NU		PWR SEAT COMVO W/SHEAR	PA		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E1007	NU	SC	PWR SEAT COMBO W/SHEAR	PA		
E1008	RB		PWR SEAT COMBO PWR SHEAR	CMN		
E1008	RB	SC	PWR SEAT COMBO PWR SHEAR	CMN		
E1008	NU		PWR SEAT COMBO PWR SHEAR	PA		
E1008	NU	SC	PWR SEAT COMBO PWR SHEAR	PA		
E1009	RB		ADD MECH LEG ELEVATION	PA	MSRP	
E1009	RB	SC	ADD MECH LEG ELEVATION	PA	MSRP	
E1009	NU		ADD MECH LEG ELEVATION	PA	MSRP	
E1009	NU	SC	ADD MECH LEG	PA	MSRP	
E1010	RB		ADDITION TO POWER SEATING SYSTEM, POWER LEG ELEVATION	CMN		
E1010	RB	SC	ADDITION TO POWER SEATING SYSTEM POWER LEG ELEVATION	CMN		
E1010	NU		ADDITION TO POWER SEATING SYSTEM, POWER LEG ELEVATION	PA		
E1010	NU	SC	ADDITION TO POWER SEATING SYSTEM POWER LEG ELEVATION	PA		
E1011	RB		MOD TO PEDIATRIC SZ CHAIR WIDTH	CMN	MSRP	
E1011	RB	SC	MOD TO PEDIATRIC SZ CHAIR WIDTH	CMN	MSRP	
E1011	NU		MOD TO PEDIATRIC SZ CHAIR WIDTH ADJUSTMENT PACKAGE	PA	MSRP	
E1011	NU	SC	MOD TO PEDIATRIC SZ CHAIR WIDTH	PA	MSRP	
E1012	RB		CTR MOUNT PWR ELEV LEG REST	CMN	MSRP	
E1012	NU		CTR MOUNT PWR ELEV LEG REST	PA	MSRP	
E1012	RR		CTR MOUNT PWR ELEV LEG REST	PA	MSRP	

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E1014	NU		RECLINING BACK FOR PEDIATRIC SZ CHAIR	PA		
E1014	NU	SC	RECLINING BACK FOR PEDIATRIC SZ CHAIR	PA		
E1014	RB		RECLINING BACK FOR PEDIATRIC SZ CHAIR	PA		
E1014	RB	SC	RECLINING BACK FOR PEDIATRIC SZ CHAIR	PA		
E1015	RB		SHOCK ABSORBER FOR MAN W/C	CMN		
E1015	RB	SC	SHOCK ABSORBER FOR MAN W/C	CMN		
E1015	NU		SHOCK ABSORBER FOR MAN W/C	CMN		
E1015	NU	SC	SHOCK ABSORBER FOR MAN W/C	PA		
E1016	RB		SHOCK ABSORBER FOR PWR W/C	CMN		
E1016	RB	SC	SHOCK ABSORBER FOR PWR W/C	CMN		
E1016	NU		SHOCK ABSORBER FOR POWER W/C	CMN		
E1016	NU	SC	SHOCK ABSORBER FOR PWR W/C	PA		
E1017	RB		HD SHCK ABSRBR FOR HD MAN WC	CMN	MSRP	
E1017	RB	SC	HD SHCK ABSRBR FOR HD MAN WC	CMN	MSRP	
E1017	NU		HD SHCK ABSRBR FOR HD MAN WC	CMN	MSRP	
E1017	NU	SC	HD SHCK ABSRBR FOR HD MAN WC	PA	MSRP	
E1018	RB		HD SHCK ABSRBER FOR HD POWWC	CMN	MSRP	
E1018	RB	SC	HD SHCK ABSRBER FOR HD POWWC	CMN	MSRP	
E1018	NU		HD SHCK ABSRBER FOR HD POWWC	PA	MSRP	
E1018	NU	SC	HD SHCK ABSRBER FOR HD POWWC	PA	MSRP	
E1020	RB		RESIDUAL LIMB SUPPORT SYSTEM	CMN		
E1020	RB	SC	RESIDUAL LIMB SUPPORT SYSTEM	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E1020	NU		RESIDUAL LIMB SUPPORT SYSTEM	CMN		
E1020	NU	SC	RESIDUAL LIMB SUPPORT SYSTEM	PA		
E1028	RB		W/C MANUAL SWINGAWAY RETRACT/REMOV MNTG HARDWARE FOR JOYSTICK OTHER CONTROL INTERFACE OR POST ACCES	CMN		8
E1028	RB	SC	W/C MANUAL SWINGAWAY RETRACT/REMOV MNTG HARDWARE FOR JOYSTICK OTHER CONTROL INTERFACE OR POST ACCES	CMN		8
E1028	NU		W/C MANUAL SWINGAWAY RETRACT/REMOV MNTGY HARDWARE FOR JOYSTICK OTHER CONTROL INTERFACE OR POST ACCES	CMN		8
E1028	NU	SC	W/C MANUAL SWINGAWAY RETRACT/REMOV MNTG HARDWARE FOR JOYSTICK OTHER CONTROL INTERFACE OR POST ACCES	PA		MAX LIMIT OF 5 ADDITIONAL UNITS MUST BE INCLUDED UNDER K0108
E1029	RB		W/C VENT TRAY FIXED	CMN		
E1029	RB	SC	W/C VENT TRAY FIXED	CMN		
E1029	NU		W/C VENT TRAY FIXED	CMN		
E1029	NU	SC	W/C VENT TRAY FIXED	PA		
E1030	RB		ROLLABOUT CHAIR, WITHOUT ARMS	CMN		
E1030	RB	SC	W/C VENT TRAY GIMBALED	CMN		
E1030	NU		W/C VENT TRAY GIMBALED	CMN		
E1030	NU	SC	W/C VENT TRAY GIMBALED	PA		
E1031	RB		GERIATRIC CHAIR	CMN	MSRP	
E1031	NU		GERIATRIC CHAIR	CMN		
E1031	RR		GERIATRIC CHAIR	CMN 1st claim only		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E1066	RB		BATTERY CHARGER	CMN		
E1161	RB		MANUAL ADULT WC W TILTINSPAC	CMN	MSRP	
E1161	RB	SC	MANUAL ADULT WC W TILTINSPAC	CMN	MSRP	
E1161	RR		MANUAL ADULT WC W TILTINSPAC	PA		
E1161	RR	SC	MANUAL ADULT WC W TILTINSPAC	PA		
E1161	NU		MANUAL ADULT WC W TILTINSPACE	PA		
E1161	NU	SC	MANUAL ADULT WC W TILTINSPACE	PA		
E1225	NU		MANUAL SEMI RECLINING BACK, RECLINE GREATER THAN 15	PA		
E1225	NU	SC	MANUAL SEMI RECLINING BACK, RECLINE GREATER THAN 15	PA		
E1226	NU		MANUAL FULLY RECLINING BACK, RECLINE GREATER THAN 80	PA		
E1226	NU	SC	MANUAL FULLY RECLINING BACK, RECLINE GREATER THAN 80	PA		
E1227	RB		SPECIAL HEIGHT ARMS FOR WHEELCHAIR	CMN		
E1227	RB	SC	SPECIAL HEIGHT ARMS FOR WHEELCHAIR	CMN		
E1227	NU		SPECIAL HEIGHT ARMS FOR WHEELCHAIR	CMN		
E1227	NU	SC	SPECIAL HEIGHT ARMS FOR WHEELCHAIR	PA		
E1228	RB		SPECIAL BACK HEIGHT FOR WHEELCHAIR	CMN		
E1228	RB	SC	SPECIAL BACK HEIGHT FOR WHEELCHAIR	CMN		
E1228	NU		SPECIAL BACK HEIGHT FOR WHEELCHAIR	CMN		
E1228	NU	SC	SPECIAL BACK HEIGHT FOR WHEELCHAIR	PA		
E1229	RB		PEDIATRIC WHEELCHAIR NOS	CMN	MSRP	
E1229	RB	SC	PEDIATRIC WHEELCHAIR NOS	CMN	MSRP	
E1229	NU		NOS PEDIATRIC SIZE WHEELCHAIR	PA	MSRP	

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E1229	NU	SC	NOS PEDIATRIC SIZE WHEELCHAIR	PA	MSRP	
E1229	RR		NOS PEDIATRIC SIZE WHEELCHAIR	PA	MSRP	
E1229	RR	SC	NOS PEDIATRIC SIZE WHEELCHAIR	PA	MSRP	
E1231	RB		RIGID PED W/C TILT-IN-SPACE	CMN	MSRP	
E1231	NU		RIGID PED W/C TILT-IN-SPACE	PA	MSRP	
E1232	RB		FOLDING PED WC TILT-IN-SPACE	CMN	MSRP	
E1232	RB	SC	FOLDING PED WC TILT-IN-SPACE	CMN	MSRP	
E1232	NU		FOLDING PED WC TILT-IN-SPACE	PA	MSRP	
E1232	NU	SC	FOLDING PED WC TILT-IN-SPACE	PA	MSRP	
E1233	RB		RIG PED WC TLTNSPC W/O SEAT	CMN	MSRP	
E1233	RB	SC	RIG PED WC TLTNSPC W/O SEAT	CMN	MSRP	
E1233	NU		RIG PED WC TLTNSPC W/O SEAT	PA	MSRP	
E1233	NU	SC	RIG PED WC TLTNSPC W/O SEAT	PA	MSRP	
E1234	RB		FLD PED WC TLTNSPC W/O SEAT	CMN	MSRP	
E1234	RB	SC	FLD PED WC TLTNSPC W/O SEAT	CMN	MSRP	
E1234	NU		FLD PED WC TLTNSPC W/O SEAT	PA	MSRP	
E1234	NU	SC	FLD PED WC TLTNSPC W/O SEAT	PA	MSRP	
E1235	RB		RIGID PED WC ADJUSTABLE	CMN	MSRP	
E1235	RB	SC	RIGID PED WC ADJUSTABLE	CMN	MSRP	
E1235	NU		RIGID PED WC ADJUSTABLE	PA	MSRP	
E1235	NU	SC	RIGID PED WC ADJUSTABLE	PA	MSRP	
E1236	RB		FOLDING PED WC ADJUSTABLE	CMN	MSRP	

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E1236	RB	SC	FOLDING PED WC ADJUSTABLE	CMN	MSRP	
E1236	NU		FOLDING PED WC ADJUSTABLE	PA	MSRP	
E1236	NU	SC	FOLDING PED WC ADJUSTABLE	PA	MSRP	
E1236	RR		FOLDING PED WC ADJUSTABLE	PA	MSRP	
E1237	RB		RGD PED WC ADJSTABL W/O SEAT	CMN	MSRP	
E1237	RB	SC	RGD PED WC ADJSTABL W/O SEAT	CMN	MSRP	
E1237	NU		RGD PED WC ADJSTABL W/O SEAT	PA	MSRP	
E1237	NU	SC	RGD PED WC ADJSTABL W/O SEAT	PA	MSRP	
E1238	RB		FLD PED WC ADJSTABL W/O SEAT	CMN	MSRP	
E1238	RB	SC	FLD PED WC ADJSTABL W/O SEAT	CMN	MSRP	
E1238	NU		FLD PED WC ADJSTABL W/O SEAT	PA	MSRP	
E1238	NU	SC	FLD PED WC ADJSTABL W/O SEAT	PA	MSRP	
E1239	RB		NOS PEDIATRIC SZ W/CH POWER	CMN	MSRP	
E1239	RB	SC	NOS PEDIATRIC SZ W/CH PWR	CMN	MSRP	
E1239	NU		NOS PEDIATRIC SZ W/CH POWER	PA	MSRP	
E1239	NU	SC	NOS PEDIATRIC SZ W/CH PWR	PA	MSRP	
E1239	RR		NOS PEDIATRIC SZ W/CH POWER	PA	MSRP	
E1239	RR	SC	NOS PEDIATRIC SZ W/CH PWR	PA	MSRP	
E1296	RB		SPECIAL WHEELCHAIR SEAT HEIGHT FROM FLOOR	PA		
E1296	RB	SC	SPECIAL WHEELCHAIR SEAT HEIGHT FROM FLOOR	PA		
E1296	NU		SPECIAL WHEELCHAIR SEAT HEIGHT FROM FLOOR	PA		
E1296	NU	SC	SPECIAL WHEELCHAIR SEAT HEIGHT FROM FLOOR	PA		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E1297	RB		SPECIAL WHEELCHAIR SEAT DEPTH, BY UPHOLSTERY	PA		
E1297	RB	SC	SPECIAL WHEELCHAIR SEAT DEPTH, BY UPHOLSTERY	PA		
E1297	NU		SPECIAL WHEELCHAIR SEAT DEPTH, BY UPHOLSTERY	PA		
E1297	NU	SC	SPECIAL WHEELCHAIR SEAT DEPTH BY UPHOLSTERY	PA		
E1298	RB		SPECIAL WHEELCHAIR SEAT DEPTH AND/OR WIDTH, BY CONSTRUCTION	PA		
E1298	RB	SC	SPECIAL WHEELCHAIR SEAT DEPTH AND/OR WIDTH BY CONSTRUCTION	PA		
E1298	NU		SPECIAL WHEELCHAIR SEAT DEPTH AND/OR WIDTH, BY CONSTRUCTION	PA		
E1298	NU	SC	SPECIAL WHEELCHAIR SEAT DEPTH AND/OR WIDTH BY CONSTRUCTION	PA		
E1390	RR	QG	OXYGEN CONCENTRATOR, CAPABLE OF DEL 85% OR > OXYGEN CONCENTRATION; > 4 LPM;	PC		CONTINUOUS RENTAL
E1390	RR		OXYGEN CONCENTRATOR,CAPABLE OF DELIVERING 85 PERCENT OR GREATER OXYGEN CONCENTRATION AT THE PRESCRIB	PC		CONTINUOUS RENTAL
E1390	RR	QF	OXYGEN CONCENTRATOR, CAPABLE OF DEL 85% OR > OXYGEN CONCENTRATION; > 4LPM W/ PORTABLE OXYGEN PRESCRI	PC		CONTINUOUS RENTAL
E1800	RB		DYNAMIC ADJUSTABLE ELBOW EXTENSION/FLEXION DEVICE	CMN	IOC	
E1800	NU		DYNAMIC ADJUSTABLE ELBOW EXTENSION/FLEXION DEVICE	CMN		
E1801	NU		SPS ELBOW DEVICE	CMN		
E1805	RB		DYNAMIC ADJUSTABLE WRIST EXTENSION/FLEXION DEVICE	CMN	IOC	
E1805	NU		DYNAMIC ADJUSTABLE WRIST EXTENSION/FLEXION DEVICE	CMN		
E1806	NU		SPS WRIST DEVICE	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E1810	RB		DYNAMIC ADJUSTABLE KNEE EXTENSION/FLEXION DEVICE	CMN	IOC	
E1810	NU		DYNAMIC ADJUSTABLE KNEE EXTENSION/FLEXION DEVICE	CMN		
E1811	NU		SPS KNEE DEVICE	CMN		
E1812	NU		DYNAMIC KNEE, EXTENSION/FLEXION DEVICE W/ACTIVE RESISTANCE CONTROL	CMN	IOC	
E1815	RB		DYNAMIC ADJUSTABLE ANKLE EXTENSION/FLEXION DEVICE	CMN	IOC	
E1815	NU		DYNAMIC ADJUSTABLE ANKLE EXTENSION/FLEXION DEVICE	CMN		
E1816	NU		SPS ANKLE DEVICE	CMN		
E1818	NU		SPS FOREARM DEVICE	CMN		
E1820	RB		SOFT INTERFACE MATERIAL, DYNAMIC ADJUSTABLE EXTENSION/FLEXION DEVICE	CMN	IOC	
E1820	NU		SOFT INTERFACE MATERIAL, DYNAMIC ADJUSTABLE EXTENSION/FLEXION DEVICE	CMN		
E1821	NU		REPLACEMENT SOFT INTERFACE MATERIAL/CUFFS FOR BI-IRECTIONAL STAT IC PROGRESSIVE STRETCH DEVICE	CMN		
E1825	RB		DYNAMIC ADJUSTABLE FINGER EXTENSION/FLEXION DEVICE	CMN	IOC	
E1825	NU		DYNAMIC ADJUSTABLE FINGER EXTENSION/FLEXION DEVICE	CMN		
E1830	RB		DYNAMIC ADJUSTABLE TOE EXTENSION/FLEXION DEVICE	CMN	IOC	
E1830	NU		DYNAMIC ADJUSTABLE TOE EXTENSION/FLEXION DEVICE	CMN		
E1831	NU		STATIC STR TOE DEV EXT/FLEX	CMN	IOC	
E1840	NU		DYNAMIC ADJUSTABLE SHOULDER FLEXION/ABDUCTION/ROTATION DEVICE, INCLUDES SOFT INTERFACE MATERIAL	CMN		
E1841	NU		STATIC STR SHLDR DEV ROM ADJ	PA	IOC	

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E1902	RB		COMMUNICATION BOARD, NONELEC.	CMN	IOC	
E1902	NU		COMMUNICATION BOARD, NONELEC.	PC, AUG COM EVAL	IOC	
E1902	NU	NR	COMMUNICATION BOARD, NONELEC.	PC	IOC	
E1902	RR		COMMUNICATION BOARD, NONELEC.	PC	IOC	
E2201	RB		MAN W/C ACC SEAT W>20 <24	CMN		
E2201	RB	SC	MAN W/C ACC SEAT W>20 <24	CMN		
E2201	NU		MAN W/C ACC SEAT W>=20 <24	CMN		
E2201	NU	SC	MAN W/C ACC SEAT W>20 <24	PA		
E2202	RB		SEAT WIDTH 24-27 IN	CMN		
E2202	RB	SC	SEAT WIDTH 24-27 IN	CMN		
E2202	NU		SEAT WIDTH 24-27 IN	CMN		
E2202	NU	SC	SEAT WIDTH 24-27 IN	PA		
E2203	RB		FRAME DEPTH LESS THAN 22 IN	CMN		
E2203	RB	SC	FRAME DEPTH LESS THAN 22 IN	CMN		
E2203	NU		FRAME DEPTH LESS THAN 22 IN	CMN		
E2203	NU	SC	FRAME DEPTH LESS THAN 22 IN	PA		
E2204	RB		FRAME DEPTH 22 TO 25 IN	CMN		
E2204	RB	SC	FRAME DEPTH 22 TO 25 IN	CMN		
E2204	NU		FRAME DEPT 22 TO 25 IN	CMN		
E2204	NU	SC	FRAME DEPTH 22 TO 25 IN	PA		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E2205	RB	SC	WC ACCESS HANDRIM W/O PROJECTIONS ANY TYPE REPLACEMENT	CMN		
E2205	RB		MANUAL WC ACCESSORY, HANDRIM	CMN		
E2206	RB		MAN WC WHL LOCK COMP REPL EA	CMN		
E2206	RB	SC	MAN WC WHL LOCK COMP REPL EA	CMN		
E2206	NU		MAN WC WHL LOCK COMP REPL EA	CMN		
E2207	RB		WHEELCHAIR ACCESSORY, CRUTCH AND CANE HOLDER, EACH	CMN		
E2207	RB	SC	WHEELCHAIR ACCESSORY, CRUTCH AND CANE HOLDER, EACH	CMN		
E2207	NU		MANUAL CHAIR ACCESSORY, CRUTH AND CANE HOLDER, EACH	CMN		
E2207	NU	SC	WHEELCHAIR ACCESSORY, CRUTCH AND CANE HOLDER, EACH	PA		
E2208	RB		WHEELCHAIR ACCESSORY, CYLINDER TANK CARRIER, EACH	CMN		
E2208	RB	SC	WHEELCHAIR ACCESSORY, CYLINDER TANK CARRIER, EACH	CMN		
E2208	NU		MANUAL CHAIR ACCESS. CYLINDER TANK CARRIER, EACH	CMN		
E2208	NU	SC	WHEELCHAIR ACCESSORY, CYLINDER TANK CARRIER, EACH	PA		
E2209	RB		WHEELCHAIR ACCESSORY, ARM TROUGH, EACH	CMN		
E2209	RB	SC	WHEELCHAIR ACCESSORY, ARM TROUGH, EACH	CMN		
E2209	NU		ACCESSORY, ARM TROUGH, WITH OR WITHOUT HAND SUPPORT, EACH	CMN		
E2209	NU	SC	WHEELCHAIR ACCESSORY, ARM TROUGH, EACH	PA		
E2210	RB		MANUAL CHAIR ACCESSORY, BEARINGS, ANY TYPE, REPLACEMENT ONLY, EACH	CMN		
E2210	RB	SC	WHEELCHAIR ACCESSORY, BEARINGS, ANY TYPE, REPLACEMENT ONLY, EACH	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E2211	RB		MANUAL WHEELCHAIR ACCESSORY, PNEUMATIC PROPULSION TIRE, ANY SIZE, EACH	CMN		
E2211	RB	SC	MANUAL WHEELCHAIR ACCESSORY, PNEUMATIC PROPULSION TIRE, ANY SIZE, EACH	CMN		
E2211	NU		MANUAL CHAIR ACCESSORY, PNEUMATIC PROPULSION TIRE, ANY SIZE, EACH	CMN		
E2211	NU	SC	MANUAL WHEELCHAIR ACCESSORY, PNEUMATIC PROPULSION TIRE, ANY SIZE, EACH	PA		
E2212	RB		MANUAL WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC PROPULSION TIRE, ANY SIZE, EACH	CMN		
E2212	RB	SC	MANUAL WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC PROPULSION TIRE, ANY SIZE, EACH	CMN		
E2212	NU		MANUAL CHAIR ACCESSORY, TUBE FOR PNEUMATIC PROPULSION TIRE, ANY SIZE, EACH	CMN		
E2212	NU	SC	MANUAL WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC PROPULSION TIRE, ANY SIZE, EACH	PA		
E2213	RB		MANUAL WHEELCHAIR ACCESSORY, INSERT FOR PNEUMATIC PROPULSION TIRE (REMOVABLE)	CMN		
E2213	RB	SC	MANUAL WHEELCHAIR ACCESSORY, INSERT FOR PNEUMATIC PROPULSION TIRE (REMOVABLE)	CMN		
E2213	NU		MANUAL CHAIR ACCESSORY, INSERT FOR PHEUMATIC PROPULSION TIRE, ANY SIZE, EACH	CMN		
E2213	NU	SC	MANUAL WHEELCHAIR ACCESSORY, INSERT FOR PNEUMATIC PROPULSION TIRE (REMOVABLE)	PA		
E2214	RB		MANUAL WHEELCHAIR ACCESSORY, PNEUMATIC CASTER TIRE, ANY SIZE, EACH	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E2214	RB	SC	MANUAL WHEELCHAIR ACCESSORY, PNEUMATIC CASTER TIRE, ANY SIZE, EACH	CMN		
E2214	NU		MANUAL CHAIR ACCESS. PNEUMATIC CASTER TIRE, ANY SIZE, EACH	CMN		
E2214	NU	SC	MANUAL WHEELCHAIR ACCESSORY, PNEUMATIC CASTER TIRE, ANY SIZE, EACH	PA		
E2215	RB		MANUAL WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC CASTER TIRE, ANY SIZE, EACH	CMN		
E2215	RB	SC	MANUAL WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC CASTER TIRE, ANY SIZE, EACH	CMN		
E2215	NU		MANUAL CHAIR ACCESSORY, TUBE FOR PNEUMATIC CASTER TIRE, ANY SIZE, EACH	CMN		
E2215	NU	SC	MANUAL WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC CASTER TIRE, ANY SIZE, EACH	PA		
E2216	RB		MANUAL WHEELCHAIR ACCESSORY, FOAM FILLED PROPULSION TIRE, ANY SIZE, EACH	CMN	MSRP	
E2216	RB	SC	MANUAL WHEELCHAIR ACCESSORY, FOAM FILLED PROPULSION TIRE, ANY SIZE, EACH	CMN	MSRP	
E2216	NU		MANUAL CHAIR ACCESSORY FOAM FILLED PROPULSION TIRE, ANY SIZE, EACH	CMN	MSRP	
E2216	NU	SC	MANUAL WHEELCHAIR ACCESSORY, FOAM FILLED PROPULSION TIRE, ANY SIZE, EACH	PA	MSRP	
E2217	RB		MANUAL WHEELCHAIR ACCESSORY, FOAM FILLED CASTER TIRE, ANY SIZE, EACH	CMN	MSRP	
E2217	RB	SC	MANUAL WHEELCHAIR ACCESSORY, FOAM FILLED CASTER TIRE, ANY SIZE, EACH	CMN	MSRP	

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E2217	NU		MANUAL CHAIR ACCESSORY, FOAM FILLED CASTER TIRE, ANY SIZE, EACH	CMN	MSRP	
E2217	NU	SC	MANUAL WHEELCHAIR ACCESSORY, FOAM FILLED CASTER TIRE, ANY SIZE, EACH	PA	MSRP	
E2218	RB		MANUAL WHEELCHAIR ACCESSORY, FOAM PROPULSION TIRE, ANY SIZE, EACH	CMN	MSRP	
E2218	RB	SC	MANUAL WHEELCHAIR ACCESSORY, FOAM PROPULSION TIRE, ANY SIZE, EACH	CMN	MSRP	
E2218	NU		MANUAL CHAIR ACCESSORY, FOAM PROPULSION TIRE, ANY SIZE, EACH	CMN	MSRP	
E2218	NU	SC	MANUAL WHEELCHAIR ACCESSORY, FOAM PROPULSION TIRE, ANY SIZE, EACH	PA	MSRP	
E2219	RB		MANUAL WHEELCHAIR ACCESSORY, FOAM CASTER TIRE, ANY SIZE, EACH	CMN		
E2219	RB	SC	MANUAL WHEELCHAIR ACCESSORY, FOAM CASTER TIRE, ANY SIZE, EACH	CMN		
E2219	NU		MANUAL CHAIR ACCESSORY, FOAM CASTER TIRE, ANY SIZE, EACH	CMN		
E2219	NU	SC	MANUAL WHEELCHAIR ACCESSORY, FOAM CASTER TIRE, ANY SIZE, EACH	PA		
E2220	RB		SOLID PROPULS TIRE, REPL, EACH	CMN		
E2220	RB	SC	SOLID PROPULS TIRE, REPL, EACH	CMN		
E2220	NU		SOLID PROPULS TIRE, REPL, EACH	CMN		
E2220	NU	SC	SOLID PROPULS TIRE, REPL, EACH	PA		
E2221	RB		SOLID CASTER TIRE REPL, EACH	CMN		
E2221	RB	SC	SOLID CASTER TIRE REPL, EACH	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E2221	NU		SOLID CASTER TIRE REPL, EACH	CMN		
E2221	NU	SC	SOLID CASTER TIRE REPL, EACH	PA		
E2222	RB		SOLID CASTER INTEG WHL, REPL	CMN		
E2222	RB	SC	SOLID CASTER INTEG WHL, REPL	CMN		
E2222	NU		SOLID CASTER INTEG WHL, REPL	CMN		
E2222	NU	SC	SOLID CASTER INTEG WHL, REPL	PA		
E2224	RB		PROPULSION WHL EXCL TIRE REP	CMN		
E2224	RB	SC	PROPULSION WHL EXCL TIRE REP	CMN		
E2224	NU		PROPULSION WHL EXCL TIRE REP	CMN		
E2224	NU	SC	PROPULSION WHL EXCL TIRE REP	PA		
E2225	RB		MANUAL CHAIR ACCESSORY, CASTER WHEEL EXCLUDES TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	CMN		
E2225	RB	SC	MANUAL WHEELCHAIR ACCESSORY, CASTER WHEEL EXCLUDES TIRE, ANY SIZE, REPLACEMENT ONLY	CMN		
E2226	RB		MANUAL CHAIR ACCESSORY, CASTER FORK, ANY SIZE, REPLACEMENT ONLY, EACH	CMN		
E2226	RB	SC	MANUAL WHEELCHAIR ACCESSORY, CASTER FORK, ANY SIZE, REPLACEMENT ONLY, EACH	CMN		
E2228	RB		MWC ACC, WHEELCHAIR BRAKE	CMN	MSRP	
E2228	RB	SC	MWC ACC, WHEELCHAIR BRAKE	CMN	MSRP	
E2228	NU		MWC ACC, WHEELCHAIR BRAKE	PA	MSRP	
E2228	NU	SC	MWC ACC, WHEELCHAIR BRAKE	PA	MSRP	
E2231	RB		MANUAL WHEELCHAIR ACCESSORY, SOLID SEAT SUPPORT BASE (REPLACES SLING SEAT)	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E2231	RB	SC	MANUAL WHEELCHAIR ACCESSORY, SOLID SEAT SUPPORT BASE (REPLACES SLING SEAT)	CMN		
E2231	NU		MANUAL WHEELCHAIR ACCESSORY, SOLID SEAT SUPPORT BASE (REPLACES SLING SEAT)	CMN		
E2231	NU	SC	MANUAL WHEELCHAIR ACCESSORY, SOLID SEAT SUPPORT BASE (REPLACES SLING SEAT)	PA		
E2291	RB		BACK PLANAR FOR PED W/C INCLUDING FXD ATTACH HARDWARE	CMN	MSRP	
E2291	RB	SC	BACK PLANAR FOR PED W/C INCLUDING FXD ATTACH HARDWARE	CMN	MSRP	
E2291	NU		BACK PLANAR, FOR PED W/C INCLUDING FXD ATTACH HARDWARE	PA	MSRP	
E2291	NU	SC	BACK PLANAR FOR PED W/C INCLUDING FXD ATTACH HARDWARE	PA	MSRP	
E2292	RB		SEAT PLANAR PED SZ W/C INCLUDES FXD ATTACH HARDWARE	CMN	MSRP	
E2292	RB	SC	SEAT PLANAR PED SZ W/C INCLUDES FXD ATTACH HARDWARE	CMN	MSRP	
E2292	NU		SEAT PLANAR PED SZ W/C INCLUDES FXD ATTACHING HARDWARE	PA	MSRP	
E2292	NU	SC	SEAT PLANAR PED SZ W/C INCLUDES FXD ATTACH HARDWARE	PA	MSRP	
E2293	RB		PED SZ W/C BACK CONTOURED FXD ATTACHING	CMN	MSRP	
E2293	RB	SC	PED SZ W/C BACK CONTOURED FXD ATTACHING	CMN	MSRP	
E2293	NU		PED SZ W/C BACK CONTOURED FIXED ATTACHING	PA	MSRP	
E2293	NU	SC	PED SZ W/C BACK CONTOURED FIXED ATTACHING	PA	MSRP	
E2294	RB		SEAT CONTOURED PED SZ WC INCLUDING FXD ATTACHING	CMN	MSRP	
E2294	RB	SC	SEAT CONTOURED PED SZ WC INCLUDING FXD ATTACHING	CMN	MSRP	

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E2294	NU		SEAT CONTOURED PED SZ, WC INCLUDING FXD ATTACHINIG	PA	MSRP	
E2294	NU	SC	SEAT CONTOURED PED SZ WC INCLUDING FXD ATTACHING	PA	MSRP	
E2295	RB		MANUAL WHEELCHAIR ACCESSORY, FOR PEDIATRIC SIZE WHEELCHAIR, DYNAMIC SEATING	CMN	MSRP	
E2295	NU		MANUAL WHEELCHAIR ACCESSORY, FOR PEDIATRIC SIZE WHEELCHAIR, DYNAMIC SEATING	PA	MSRP	
E2310	RB		ELECTRO CONNECT BTW CONTROL	CMN		
E2310	RB	SC	ELECTRO CONNECT BTW CONTROL	CMN		
E2310	NU		ELECTRO CONNECT BTW CONTROL	PA		
E2310	NU	SC	ELECTRO CONNECT BTW CONTROL	PA		
E2311	RB		ELECTRO CONNECT BTW 2 SYS	CMN		
E2311	RB	SC	ELECTRO CONNECT BTW 2 SYS	CMN		
E2311	NU		ELECTRO CONNECT BTW 2 SYS	PA		
E2311	NU	SC	ELECTRO CONNECT BTW 2 SYS	PA		
E2312	RB		MINI-PROP REMOTE JOYSTICK	CMN		
E2312	RB	SC	MINI-PROP REMOTE JOYSTICK	CMN		
E2312	NU		MINI-PROP REMOTE JOYSTICK	PA		
E2312	NU	SC	MINI-PROP REMOTE JOYSTICK	PA		
E2313	RB		PWC HARNESS, EXPAND CONTROLLER	CMN		
E2313	RB	SC	PWC HARNESS, EXPAND CONTROLLER	CMN		
E2313	NU		PWC HARNESS, EXPAND CONTROL	PA		
E2313	NU	SC	PWC HARNESS, EXPAND CONTROLLER	PA		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E2321	RB		HAND INTERFACE JOYSTICK	CMN		
E2321	RB	SC	HAND INTERFACE JOYSTICK	CMN		
E2321	NU		HAND INTERFACE JOYSTICK	PA		
E2321	NU	SC	HAND INTERFACE JOYSTICK	PA		
E2322	RB		MULT MECH SWITCHES	CMN		
E2322	RB	SC	MULT MECH SWITCHES	CMN		
E2322	NU		MULT MECH SWITCHES	PA		
E2322	NU	SC	MULT MECH SWITCHES	PA		
E2323	RB		SPECIAL JOYSTICK HANDLE	CMN		
E2323	RB	SC	SPECIAL JOYSTICK HANDLE	CMN		
E2323	NU		SPECIAL JOYSTICK HANDLE	CMN		
E2323	NU	SC	SPECIAL JOYSTICK HANDLE	PA		
E2324	RB		CHIN CUP INTERFACE	CMN		
E2324	NU		CHIN CUP INTERFACE	CMN		
E2324	RB	SC	CHIN CUP INTERFACE	PA		
E2324	NU	SC	CHIN CUP INTERFACE	PA		
E2325	RB		SIP AND PUFF INTERFACE	CMN		
E2325	RB	SC	SIP AND PUFF INTERFACE	CMN		
E2325	NU		SIP AND PUFF INTERFACE	PA		
E2325	NU	SC	SIP AND PUFF INTERFACE	PA		
E2326	RB		BREATH TUBE KIT	CMN		
E2326	RB	SC	BREATH TUBE KIT	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E2326	NU		BREATH TUBE KIT	CMN		
E2326	NU	SC	BREATH TUBE KIT	PA		
E2327	RB		HEAD CONTROL INTERFACE MECH	CMN		
E2327	RB	SC	HEAD CONTROL INTERFACE MECH	CMN		
E2327	NU		HEAD CONTROL INTERFACE MECH	PA		
E2327	NU	SC	HEAD CONTROL INTERFACE MECH	PA		
E2328	RB		HEAD EXTREMITY CONTROL INTER	CMN		
E2328	RB	SC	HEAD EXTREMITY CONTROL INTER	CMN		
E2328	NU		HEAD EXTREMITY CONTROL INTER	PA		
E2328	NU	SC	HEAD EXTREMITY CONTROL INTER	PA		
E2329	RB		HEAD CONTROL NONPROPORTIONAL	CMN		
E2329	RB	SC	HEAD CONTROL NONPROPORTIONAL	CMN		
E2329	NU		HEAD CONTROL NONPROPORTIONAL	PA		
E2329	NU	SC	HEAD CONTROL NONPROPORTIONAL	PA		
E2330	RB		HEAD CONTROL PROXIMITY SWITCH	CMN		
E2330	RB	SC	HEAD CONTROL PROXIMITY SWITCH	CMN		
E2330	NU		HEAD CONTROL PROSIMITY SWITCH	PA		
E2330	NU	SC	HEAD CONTROL PROXIMITY SWITCH	PA		
E2331	RB		ATTENDANT CONTROL	PA	MSRP	
E2331	RB	SC	ATTENDANT CONTROL	PA	MSRP	
E2331	NU		ATTENDANT CONTROL	PA	MSRP	
E2331	NU	SC	ATTENDANT CONTROL	PA	MSRP	

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E2340	RB		W/C WIDTH 20-23 IN SEAT FRAME	PA		
E2340	RB	SC	W/C WIDTH 20-23 IN SEAT FRAME	PA		
E2340	NU		W/C WIDTH 20-23 IN SEAT FRAME	PA		
E2340	NU	SC	W/C WIDTH 20-23 IN SEAT FRAME	PA		
E2341	RB		W/C WIDTH 24-27 IN SEAT FRAME	PA		
E2341	RB	SC	W/C WIDTH 24-27 IN SEAT FRAME	PA		
E2341	NU		W/C WIDTH 24-27 IN SEAT FRAME	PA		
E2341	NU	SC	W/C WIDTH 24-27 IN SEAT FRAME	PA		
E2342	RB		W/C DEPTH 20-21 IN SEAT FRAME	PA		
E2342	RB	SC	W/C DEPTH 20-21 IN SEAT FRAME	PA		
E2342	NU		W/C DEPTH 20-21 IN SEAT FRAME	PA		
E2342	NU	SC	W/C DEPTH 20-21 IN SEAT FRAME	PA		
E2343	RB		W/C DEPTH 22-25 IN SEAT FRAME	PA		
E2343	RB	SC	W/C DEPTH 22-25 IN SEAT FRAME	PA		
E2343	NU		W/C DEPTH 22-25 IN SEAT FRAME	PA		
E2343	NU	SC	W/C DEPTH 22-25 IN SEAT FRAME	PA		
E2351	RB		ELECTRONIC SGD INTERFACE	CMN		
E2351	RB	SC	ELECTRONIC SGD INTERFACE	CMN		
E2351	NU		ELECTRONIC SGD INTERFACE	PA		
E2351	NU	SC	ELECTRONIC SGD INTERFACE	PA		
E2359	RB		GR34 SEALED LEADACID BATTERY	MNF		
E2359	RB	SC	GR34 SEALED LEADACID BATTERY	MNF		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E2359	NU		GR34 SEALED LEADACID BATTERY	MNF		
E2359	NU	SC	GR34 SEALED LEADACID BATTERY	PA		
E2360	NU		22 NF NON-SEALED LEAD ACID BATTERY, EACH			
E2360	RB		22 NF NON-SEALED ACID BATTERY, EACH	MNF		
E2360	RB	SC	22 NF NON-SEALED ACID BATTERY, EACH	MNF		
E2360	NU	SC	22 NF NON-SEALED ACID BATTERY, EACH	PA		
E2361	NU		22 NF SEALED LEAD ACID BATTERY, EACH			
E2361	RB		22 NF SEALED LEAD ACID BATTERY, EACH	MNF		
E2361	RB	SC	22 NF SEALED LEAD ACID BATTERY, EACH	MNF		
E2361	NU	SC	22 NF SEALED LEAD ACID BATTERY, EACH	PA		
E2362	NU		GROUP 24NON-SEALED LEAD ACID BATTERY, EACH			
E2362	RB		GROUP 24 NON-SEALED LEAD ACID BATTERY, EACH	MNF		
E2362	RB	SC	GROUP 24 NON-SEALED LEAD ACID BATTERY, EACH	MNF		
E2362	NU	SC	GROUP 24 NON-SEALED LEAD ACID BATTERY, EACH	PA		
E2363	NU		GROUP 24 SEALED LEAD ACID BATTERY, EACH			
E2363	RB		GROUP 24 SEALED LEAD ACID BATTERY, EACH	MNF		
E2363	RB	SC	GROUP 24 SEALED LEAD ACID BATTERY, EACH	MNF		
E2363	NU	SC	GROUP 24 SEALED LEAD ACID BATTERY, EACH	PA		
E2364	NU		U-1 NON-SEALED LEAD ACID BATTERY			
E2364	RB		U-1 NON-SEALED LEAD ACID BATTERY	MNF		
E2364	RB	SC	U-1 NON-SEALED LEAD ACID BATTERY	MNF		
E2364	NU	SC	U-1 NON-SEALED LEAD ACID BATTERY	PA		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E2365	NU		U-1 SEALED LEAD ACID BATTERY, EACH			
E2365	RB		U-1 SEALED LEAD ACID BATTERY, EACH	MNF		
E2365	RB	SC	U-1 SEALED LEAD ACID BATTERY, EACH	MNF		
E2365	NU	SC	U-1 SEALED LEAD ACID BATTERY, EACH	PA		
E2366	NU		BATTERY CHARGER SINGLE MODE			
E2366	RB		BATTERY CHARGER SINGLE MODE	MNF		
E2366	RB	SC	BATTERY CHARGER SINGLE MODE	MNF		
E2367	RB		BATTERY CHARGER DUAL MODE	MNF		
E2367	RB	SC	BATTERY CHARGER DUAL MODE	MNF		
E2368	RB		PWR WC DRIVEWHEEL MOTOR REPL	CMN		
E2368	RB	SC	PWR WC DRIVEWHEEL MOTOR REPL	CMN		
E2369	RB		PWR WC DRIVEWHEEL GEAR REPL	CMN		
E2369	RB	SC	PWR WC DRIVEWHEEL GEAR REPL	CMN		
E2370	RB		PWR WC DR WH MOTOR/GEAR COMB	CMN		
E2370	RB	SC	PWR WC DR WH MOTOR/GEAR COMB	CMN		
E2371	RB		PWR W/C ACCESSORY, GROUP 27 SEALED LEAD ACID BATTERY (E.G. GELL CELL, ABSORBED GLASSMAT)	CMN		
E2371	RB	SC	PWR W/C ACCESSORY, GROUP 27 SEALED LEAD ACID BATTERY (E.G. GELL CELL, ABSORBED GLASSMAT)	CMN		
E2371	NU		POWER CHAIR ACCESSORY, GROUP 27 SEALED LEAD ACID BATTERY, (E.G. GEL), EACH	CMN		
E2371	NU	SC	PWR W/C ACCESSORY, GROUP 27 SEALED LEAD ACID BATTERY (E.G. GELL CELL, ABSORBED GLASSMAT)	PA		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E2372	RB		PWR W/C ACCESSORY, GROUP 27 NON-SEALED LEAD ACID BATTERY, EACH	CMN	MSRP	
E2372	RB	SC	PWR W/C ACCESSORY, GROUP 27 NON-SEALED LEAD ACID BATTERY, EACH	CMN	MSRP	
E2372	NU		POWER CHAIR ACCESSORY, GROUP 27 NON-SEALED LEAD ACID BATTERY, EACH	CMN	MSRP	
E2372	NU	SC	PWR W/C ACCESSORY, GROUP 27 NON-SEALED LEAD ACID BATTERY, EACH	PA	MSRP	
E2373	NU		HAND/CHIN CTRL SPEC JOYSTICK	CMN		
E2373	RB		HAND CHIN CONTROL	CMN		
E2373	RB	SC	HAND CHIN CONTROL	CMN		
E2373	NU	SC	HAND CHIN CONTROL	PA		
E2374	RB		POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, STANDARD REMOTE JOYSTICK (NOT INCLUDING	CMN		
E2374	RB	SC	HAND CHIN CONTROL	CMN		
E2375	RB		POWER WHEELCHAIR ACCESSORY, NON-EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING	CMN		
E2375	RB	SC	PWC ACCESSORY, NON-EXPANDABLE CONTROLLER	CMN		
E2376	RB		POWER WHEELCHAIR ACCESSORY, EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HA	CMN		
E2376	RB	SC	PWC ACCESSORY, EXPANDABLE CONTROLLER	CMN		
E2377	RB		PWC ACCESSORY, EXPANDABLE CONTROLLER	CMN		
E2377	RB	SC	PWC ACCESSORY, EXPANDABLE CONTROLLER	PA		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E2377	NU		POWER WHEELCHAIR ACCESSORY, EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HA	PA		
E2377	NU	SC	PWC ACCESSORY, EXPANDABLE CONTROLLER	PA		
E2378	RB		PW ACTUATOR REPLACEMENT	PA	MSRP	
E2378	RB	SC	PW ACTUATOR REPLACEMENT	PA	MSRP	
E2381	RB		POWER WHEELCHAIR ACCESSORY, PNEUMATIC DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	CMN		
E2381	RB	SC	PWC ACCESSORY, PNEUMATIC DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY; EACH	CMN		
E2382	RB		POWER WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	CMN		
E2382	RB	SC	TUBE FOR PNEUMATIC TIRE WHEEL, ANY SIZE, REPLACEMENT ONLY	CMN		
E2383	RB		POWER WHEELCHAIR ACCESSORY, INSERT FOR PNEUMATIC DRIVE WHEEL TIRE (REMOVABLE), ANY TYPE, ANY SIZE, R	CMN		
E2383	RB	SC	INSERT FOR PNEUMATIC TIRE WHEEL (REMOVABLE)	CMN		
E2384	RB		POWER WHEELCHAIR ACCESSORY, PNEUMATIC CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	CMN		
E2384	RB	SC	PNEUMATIC CASTER TIRE	CMN		
E2385	RB		POWER WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	CMN		
E2385	RB	SC	TUBE FOR PNEUMATIC CASTER TIRE	CMN		
E2386	RB		POWER WHEELCHAIR ACCESSORY, FOAM FILLED DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	CMN		
E2386	RB	SC	FOAM FILLED DRIVE WHEEL TIRE	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E2387	RB		POWER WHEELCHAIR ACCESSORY, FOAM FILLED CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	CMN		
E2387	RB	SC	FOAM FILLED CASTER TIRE	CMN		
E2388	RB		POWER WHEELCHAIR ACCESSORY, FOAM DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	CMN	IOC	
E2388	RB	SC	FOAM DRIVE WHEEL TIRE	CMN		
E2389	RB		POWER WHEELCHAIR ACCESSORY, FOAM CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	CMN	IOC	
E2389	RB	SC	FOAM CASTER TIRE	CMN		
E2390	RB		POWER WHEELCHAIR ACCESSORY, SOLID (RUBBER/PLASTIC) DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EAC	CMN	IOC	
E2390	RB	SC	SOLID (RUBBER/PLASTIC) DRIVE WHEEL TIRE	CMN		
E2391	RB		POWER WHEELCHAIR ACCESSORY, SOLID (RUBBER/PLASTIC) CASTER TIRE (REMOVABLE), ANY SIZE, REPLACEMENT ON	CMN		
E2391	RB	SC	SOLID (RUBBER/PLASTIC) CASTER TIRE	CMN		
E2392	RB		POWER WHEELCHAIR ACCESSORY, SOLID (RUBBER/PLASTIC) CASTER TIRE WITH INTEGRATED WHEEL, ANY SIZE, REPL	CMN		
E2392	RB	SC	SOLID (RUBBER/PLASTIC) CASTER TIRE WITH INTEGRATED WHEEL	CMN		
E2394	RB		POWER WHEELCHAIR ACCESSORY, DRIVE WHEEL EXCLUDES TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	CMN		
E2394	RB	SC	DRIVE WHEEL EXCLUDES TIRE	CMN		
E2395	RB		POWER WHEELCHAIR ACCESSORY, CASTER WHEEL EXCLUDES TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	CMN		
E2395	RB	SC	CASTER WHEEL EXLUDES TIRE	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E2396	RB		POWER WHEELCHAIR ACCESSORY, CASTER FORK, ANY SIZE, REPLACEMENT ONLY, EACH	CMN		
E2396	RB	SC	CASTER WITH A FORK	CMN		
E2397	RB		PWC ACCESSORY, LITHIUM BASED BATTERY; EACH	IOC	MSRP	
E2397	RB	SC	PWC ACCESSORY, LITHIUM BASED BATTERY; EACY	IOC	MSRP	
E2397	NU		PWC ACC, LITH-BASED BATTERY	IOC	MSRP	
E2397	NU	SC	PWC ACCESSORY, LITHIUM BASED BATTERY; EACH	PA	MSRP	
E2398	NU		WC DYNAMIC POS BACK HARDWARE	PA	MSRP	
E2398	NU	SC	WC DYNAMIC POS BACK HARDWARE	PA	MSRP	
E2398	RB		WC DYNAMIC POS BACK HARDWARE	CMN	MSRP	
E2398	RB	SC	WC DYNAMIC POS BACK HARDWARE	CMN	MSRP	
E2398	RR		WC DYNAMIC POS BACK HARDWARE	PA	MSRP	
E2398	RR	SC	WC DYNAMIC POS BACK HARDWARE	PA	MSRP	
E2500	RB		SPCH GEN DEVICE DIGITIZED SPCH PRERECORD <=8 min	CMN	MSRP	
E2500	RR		SPCH GEN DEVICE DIGITIZED SPCH PRERECORD <=8 min	PC, AUG COM EVAL	MSRP	
E2500	NU	NR	SPCH GEN DEVICE DIGITIZED SPCH PRERECORD <=8 MIN	PC, AUG COM EVAL	MSRP	
E2500	NU		SPCH GEN DEVICE DIGITIZED SPCH PRERECORD <=8 min	PC, AUG COM EVAL	MSRP	
E2502	RB		SPCH GEN DEVICE DIGITIZED SPCH PRERECORDED >8min<=20min	CMN	MSRP	
E2502	RR		SPCH GEN DEVICE DIGITIZED SPCH PRERECORDED >8min<=20min	PC, AUG COM EVAL		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E2502	NU	NR	SPCH GEN DEVICE DIGITIZED SPCH PREECORDED >8MIN<= 20 MIN	PC, AUG COM EVAL		
E2502	NU		SPCH GEN DEVICE DIGITIZED SPCH PRERECORDED >8min<=20min	PC, AUG COM EVAL		
E2504	RB		SPCH GEN DEVICE DIGITIZED SPCH PRERECORDED >20min<=40min	CMN	MSRP	
E2504	RR		SPCH GEN DEVICE DIGITIZED SPCH PRERECORDED >20min<=40min	PC, AUG COM EVAL		
E2504	NU	NR	SPCH GEN DEVICE DIGITIZED SPCH PRERECORDED >20MIN<=40 MIN	PC, AUG COM EVAL		
E2504	NU		SPCH GEN DEVICE DIGITIZED SPCH PRERECORDED >20min<=40min	PC, AUG COM EVAL		
E2506	RB		SPCH GEN DEVICE DIGITIZED SPCH PRERECORDED >40min	CMN	MSRP	
E2506	NU		SPCH GEN DEVICE DIGITIZED SPCH PRERECORDED >40min	PC, AUG COM EVAL	MSRP	
E2506	NU	NR	SPCH GEN DEVICE DIGITIZED SPCH PRERECORDED >40MIN	PC, AUG COM EVAL	MSRP	
E2506	RR		SPCH GEN DEVICE DIGITIZED SPCH PRERECORDED >40min	PC, AUG COM EVAL	MSRP	
E2508	RB		SPCH GEN DEVICE SYNTHESIZED SPCH SPELLING PHYS. CONTACT	CMN		
E2508	NU		SPCH GEN DEVICE SYNTHESIZED SPCH SPELLING PHYS. CONTACT	PC, AUG COM EVAL	MSRP	
E2508	NU	NR	SPCH GEN DEVICE SYNTHESIZED SPCH SPELLING PHYS. CONTACT	PC, AUG COM EVAL	MSRP	
E2508	RR		SPCH GEN DEVICE SYNTHESIZED SPCH SPELLING PHYS. CONTACT	PC, AUG COM EVAL	MSRP	

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E2510	RB		SPCH GEN DEVICE SYNTHESIZED SPCH PERMIT W MULTI METHODS MSG/ACCS	CMN		
E2510	NU		SPCH GEN DEVICE SYNTHESIZED SPCH PERMIT W MULTI METHODS MSG/ACCS	PC, AUG COM EVAL	MSRP	
E2510	NU	NR	SPCH GEN DEVICE SYNTHESIZED SPCH PERMIT W MULTI METHODS MSG/ACCS	PC, AUG COM EVAL	MSRP	
E2510	RR		SPCH GEN DEVICE SYNTHESIZED SPCH PERMIT W MULTI METHODS MSG/ACCS	PC, AUG COM EVAL	MSRP	
E2511	RB		SPCH GEN SOFTWARE PROGRAM FOR PC/PDA	CMN		
E2511	NU		SPCH GEN SOFTWARE PROGRAM FOR PC/PDA	PC, AUG COM EVAL	MSRP	
E2511	RR		SPCH GEN SOFTWARE PROGRAM FOR PC/PDA	PC, AUG COM EVAL	MSRP	
E2512	RB		ACCESSORY FOR SPEECH GENERATING DEVICE, MOUNTING SYSTEM	CMN		
E2512	NU		ACCESSORY FOR SPEECH GENERATING DEVICE, MOUNTING SYSTEM	PC, AUG COM EVAL	MSRP	
E2512	RR		ACCESSORY FOR SPEECH GENERATING DEVICE, MOUNTING SYSTEM	PC, AUG COM EVAL	MSRP	
E2599	RB		ACCESSORY FOR SPEECH GENERATING DEVICE, NOT OTHERWISE CLASSIFIED	CMN		
E2599	NU		ACCESSORY FOR SPEECH GENERATING DEVICE, NOT OTHERWISE CLASSIFIED	PC, AUG COM EVAL	MSRP	
E2599	RR		ACCESSORY FOR SPEECH GENERATING DEVICE, NOT OTHERWISE CLASSIFIED	PC, AUG COM EVAL	MSRP	
E2601	RB		WHEELCHAIR SEAT CUSHION WIDTH LESS THAN 22 IN ANY DEPTH	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E2601	RB	SC	WHEELCHAIR SEAT CUSHION WIDTH LESS THAN 22 IN ANY DEPTH	CMN		
E2601	NU		WHEELCHAIR SEAT CUSHION WIDTH LESS THAN 22 IN. ANY DEPTH	CMN		
E2601	NU	SC	WHEELCHAIR SEAT CUSHION WIDTH LESS THAN 22 IN ANY DEPTH	PA		
E2602	RB		WHEELCHAIR SEAT CUSHION WIDTH 22 IN OR GREAT ANY DEPTH	CNN		
E2602	RB	SC	WHEELCHAIR SEAT CUSHION WIDTH 22 IN OR GREAT ANY DEPTH	CMN		
E2602	NU		WHEELCHAIR SEAT CUSHION WIDTH 22 INCHES OR GREATER ANY DEPTH	CMN		
E2602	NU	SC	WHEELCHAIR SEAT CUSHION WIDTH 22 IN OR GREAT ANY DEPTH	PA		
E2603	RB		WHEELCHAIR SEAT CUSHION SKIN PROTECTION WIDTH LESS THAN 22 IN ANY DEPTH	CMN		
E2603	RB	SC	WHEELCHAIR SEAT CUSHION SKIN PROTECTION WIDTH LESS THAN 22 IN ANY DEPTH	CMN		
E2603	NU		WHEELCHAIR SEAT CUSHION, SKIN PROTECTION, WIDTH LESS THAN 22 IN ANY DEPTH	PA		
E2603	NU	SC	WHEELCHAIR SEAT CUSHION SKIN PROTECTION WIDTH LESS THAN 22 IN ANY DEPTH	PA		
E2604	RB		WHEELCHAIR SEAT CUSHION SKIN PROTECTION WIDTH 22 IN	CMN		
E2604	RB	SC	WHEELCHAIR SEAT CUSHION SKIN PROTECTION WIDTH 22 IN	CMN		
E2604	NU		WHEELCHAIR SEAT CUSHION SKIN PROTECT WIDTH 22 IN.	PA		
E2604	NU	SC	WHEELCHAIR SEAT CUSHION SKIN PROTECTION WIDTH 22 IN	PA		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E2605	RB		SEAT CUSHION POSITIONING WIDTH LESS THAN 22 IN ANY DEPTH	CMN		
E2605	RB	SC	SEAT CUSHION POSITIONING WIDTH LESS THAN 22 IN ANY DEPTH	CMN		
E2605	NU		SEAT CUSHION POSITIONING WIDTH LESS THAN 22 INCHES, ANY DEPTH	PA		
E2605	NU	SC	SEAT CUSHION POSITIONING WIDTH LESS THAN 22 IN ANY DEPTH	PA		
E2606	RB		SEAT CUSHION WIDTH 22 IN OR GREATER ANY DEPTH	CMN		
E2606	RB	SC	SEAT CUSHION WIDTH 22 IN OR GREATER ANY DEPTH	CMN		
E2606	NU	SC	SEAT CUSHION WIDTH 22 IN OR GREATER ANY DEPTH	PA		
E2606	NU		SEAT CHUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH	PA		
E2607	RB		SKIN PROTECTION & POSITIONING SEAT CUSHION WIDTH LESS THAN 22	CMN		
E2607	RB	SC	SKIN PROTECTION & POSITIONING SEAT CUSHION WIDTH LESS THAN 23	CMN		
E2607	NU		SKIN PROTECTION & POSITIONING SEAT CUSHION, WIDTH LESS THAN 22	PA		
E2607	NU	SC	SKIN PROTECTION & POSITIONING SEAT CUSHION WIDTH LESS THAN 22	PA		
E2608	RB		SKIN PROTECTION & POSITIONING SEAT CUSHION WIDTH 22 IN	CMN		
E2608	RB	SC	SKIN PROTECTION & POSITIONING SEAT CUSHION WIDTH 22 IN	CMN		
E2608	NU		SKIN PROTECTION AND POSITIONING SEAT CUSHION, WIDTH 22 INCHES	PA		
E2608	NU	SC	SKIN PROTECTION & POSITIONING SEAT CUSHION WIDTH 22 IN	PA		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E2609	RB		CUSTOM FABRICATED SEAT CUSHION ANY SIZE	PA	MSRP	
E2609	RB	SC	CUSTOM FABRICATED SEAT CUSHION ANY SIZE	PA	MSRP	
E2609	NU		CUSTOM FABRICATED SEAT CUSHION, ANY SIZE	PA	MSRP	
E2609	NU	SC	CUSTOM FABRICATED SEAT CUSHION ANY SIZE	PA	MSRP	
E2611	RB		BACK CUSHION WIDTH LESS THAN 22 IN ANY HEIGHT	CMN		
E2611	RB	SC	BACK CUSHION WIDTH LESS THAN 22 IN ANY HEIGHT	CNN		
E2611	NU		BACK CUSHION, WIDTH LESS THAN 22 INCHES, ANY HEIGHT	CMN		
E2611	NU	SC	BACK CUSHION WIDTH LESS THAN 22 IN ANY HEIGHT	PA		
E2612	RB		BACK CUSHION WIDTH 22 IN OR GREATER ANY HEIGHT	CMN		
E2612	RB	SC	BACK CUSHION WIDTH 22 IN OR GREATER ANY HEIGHT	CMN		
E2612	NU		BACK CUSHION, WIDTH 22 INCHES OR GREATER, ANY HEIGHT	CMN		
E2612	NU	SC	BACK CUSHION WIDTH 22 IN OR GREATER ANY HEIGHT	PA		
E2613	RB		BACK CUSHION POSTERIOR WIDTH LESS THAN 22 IN	CMN		
E2613	RB	SC	BACK CUSHION POSTERIOR WIDTH LESS THAN 22 IN	CMN		
E2613	NU		BACK CUSHION, POSTERIOR, WIDTH LESS THAN 22 INCHES	PA		
E2613	NU	SC	BACK CUSHION POSTERIOR WIDTH LESS THAN 22 IN	PA		
E2614	RB		BACK CUSHION POSTERIOR WIDTH 22 IN OR GREATER	CMN		
E2614	RB	SC	BACK CUSHION POSTERIOR WIDTH 22 IN OR GREATER	CMN		
E2614	NU		BACK CUSHION, POSTERIOR, WIDTH 22 INCHES OR GREATER	PA		
E2614	NU	SC	BACK CUSHION POSTERIOR WIDTH 22 IN OR GREATER	PA		
E2615	RB		BACK CUSHION POSTERIOR-LATERAL WIDTH LESS THAN 22 IN	CMN		
E2615	RB	SC	BACK CUSHION POSTERIOR-LATERAL WIDTH LESS THAN 22 IN	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E2615	NU		BACK CUSHION, POSTERIOR-LATERAL WIDTH LESS THAN 22 IN	PA		
E2615	NU	SC	BACK CUSHION POSTERIOR-LATERAL WIDTH LESS THAN 22 IN	PA		
E2616	RB		BACK CUSHION POSTERIOR-LATERAL WIDTH 22 IN	CMN		
E2616	RB	SC	BACK CUSHION POSTERIOR-LATERAL WIDTH 22 IN	CMN		
E2616	NU		BACK CUSHION POSTERIOR-LATERAL, WIDTH 22 INCHES	PA		
E2616	NU	SC	BACK CUSHION POSTERIOR-LATERAL WIDTH 22 IN	PA		
E2617	RB		CUSTOM FABRICATED BACK CUSHION ANY SIZE INCLUDING ANY TYPE	PA	MSRP	
E2617	RB	SC	CUSTOM FABRICATED BACK CUSHION ANY SIZE INCLUDING ANY TYPE	PA	MSRP	
E2617	NU		CUSTOM FABRICATED BACK CUSHION, ANY SIZE, INCLUDING ANY TYPE	PA	MSRP	
E2617	NU	SC	CUSTOM FABRICATED BACK CUSHION ANY SIZE INCLUDING ANY TYPE	PA	MSRP	
E2619	RB		REPLACEMENT COVER FOR SEAT OR BACK CUSHION FOR CHAIR	CMN		
E2619	RB	SC	REPLACEMENT COVER FOR SEAT OR BACK CUSHION FOR CHAIR	CMN		
E2619	NU		REPLACEMENT COVER FOR SEAT OR BACK CUSHION FOR CHAIR	CMN		
E2619	NU	SC	REPLACEMENT COVER FOR SEAT OR BACK CUSHION FOR CHAIR	PA		
E2620	RB		POSITIONING BACK CUSHION PLANAR BACK WITH LATERAL SUPPORTS	CMN		
E2620	RB	SC	POSITIONING BACK CUSHION PLANAR BACK WITH LATERAL SUPPORTS	CMN		
E2620	NU		POSITIONGING BACK CUSHION, PLANAR BACK WITH LATERAL SUPPORTS	PA		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E2620	NU	SC	POSITIONING BACK CUSHION PLANAR BACK WITH LATERAL SUPPORTS	PA		
E2621	RB		POSITIONING BACK CUSHION PLANAR BACK WITH LATERAL SUPPORTS	CMN		
E2621	RB	SC	POSITIONING BACK CUSHION PLANAR BACK WITH LATERAL SUPPORTS	CMN		
E2621	NU		POSITIONING BACK CUSHION, PLANAR BACK WITH LATERAL SUPPORTS	PA		
E2621	NU	SC	POSITIONING BACK CUSHION PLANAR BACK WITH LATERAL SUPPORTS	PA		
E2622	RB		ADJ SKIN PRO W/C CUS WD<22IN	CMN		
E2622	RB	SC	ADJ SKIN PRO W/C CUS WD<22IN	CMN		
E2622	NU		ADJ SKIN PRO W/C CUS WD<22IN	PA		
E2622	NU	SC	ADJ SKIN PRO W/C CUS WD<22IN	PA		
E2623	RB		ADJ SKIN PRO WC CUS WD>=22IN	CMN		
E2623	RB	SC	ADJ SKIN PRO WC CUS WD>=22IN	CMN		
E2623	NU		ADJ SKIN PRO WC CUS WD>=22IN	PA		
E2623	NU	SC	ADJ SKIN PRO WC CUS WD>=22IN	PA		
E2624	RB		ADJ SKIN PRO/POS CUS<22IN	CMN		
E2624	RB	SC	ADJ SKIN PRO/POS CUS<22IN	CMN		
E2624	NU		ADJ SKIN PRO/POS CUS<22IN	PA		
E2624	NU	SC	ADJ SKIN PRO/POS CUS<22IN	PA		
E2625	RB		ADJ SKIN PRO/POS WC CUS>=22	CMN		
E2625	RB	SC	ADJ SKIN PRO/POS WC CUS>=22	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
E2625	NU		ADJ SKIN PRO/POS WC CUS>=22	PA		
E2625	NU	SC	ADJ SKIN PRO/POS WC CUS>=22	PA		
K0001	RB		STANDARD WHEELCHAIR	CMN	MSRP	
K0001	RR		STANDARD WHEELCHAIR	CMN		24 MONTH RENT TO PURCHASE
K0002	RB		STND HEMI (LOW SEAT) WHLCHR	CMN	90% of MSRP	
K0002	RR		STND HEMI (LOW SEAT) WHLCHR	CMN		12 MONTH RENT TO PURCHASE
K0003	RB		LIGHTWEIGHT WHEELCHAIR	CMN	MSRP	
K0003	RR		LIGHTWEIGHT WHEELCHAIR	CMN		24 MONTH RENT TO PURCHASE
K0004	RB		HIGH STRENGTH LTWT WHLCHR	CMN	MSRP	
K0004	RB	SC	HIGH STRENGTH LTWT WHLCHR	CMN	MSRP	
K0004	RR		HIGH STRENGTH LTWT WHLCHR	CMN		12 MONTH RENT TO PURCHASE
K0004	RR	SC	HIGH STRENGTH LTWT WHLCHR	PA		12 MONTH RENT TO PURCHASE

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
K0005	RB		ULTRALIGHTWEIGHT WHEELCHAIR	CMN		
K0005	RB	SC	ULTRALIGHTWEIGHT WHEELCHAIR	CMN	MSRP	
K0005	RR		ULTRALIGHTWEIGHT WHEELCHAIR	PA		
K0005	RR	SC	ULTRALIGHTWEIGHT WHEELCHAIR	PA		
K0005	NU		ULTRALIGHTWEIGHT WHEELCHAIR	PA		
K0005	NU	SC	ULTRALIGHTWEIGHT WHEELCHAIR	PA		
K0006	RB		HEAVY DUTY WHEELCHAIR	CMN	MSRP	
K0006	RB	SC	HEAVY DUTY WHEELCHAIR	CMN	MSRP	
K0006	RR		HEAVY DUTY WHEELCHAIR	CMN		23 MONTH RENT TO PURCHASE
K0006	RR	SC	HEAVY DUTY WHEELCHAIR	PA		23 MONTH RENT TO PURCHASE
K0007	RB		EXTRA HEAVY DUTY WHEELCHAIR	CMN	MSRP	
K0007	RB	SC	EXTRA HEAVY DUTY WHEELCHAIR	CMN	MSRP	
K0007	RR		EXTRA HEAVY DUTY WHEELCHAIR	CMN		23 MONTH RENT TO PURCHASE
K0007	RR	SC	EXTRA HEAVY DUTY WHEELCHAIR	PA		23 MONTH RENT TO PURCHASE
K0008	RB		CSTM MANUAL WHEELCHAIR/BASE	CMN	90% of MSRP	
K0008	RB	SC	CSTM MANUAL WHEELCHAIR/BASE	CMN	90% of MSRP	
K0008	NU		CSTM MANUAL WHEELCHAIR/BASE	PA	90% of MSRP	

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
K0008	NU	SC	CSTM MANUAL WHEELCHAIR/BASE	PA	90% of MSRP	
K0009	RB		OTHER MANUAL WHEELCHAIR/BASE	CMN	90% of MSRP	
K0009	RB	SC	OTHER MANUAL WHEELCHAIR/BASE	CMN	90% of MSRP	
K0009	NU		OTHER MANUAL WHEELCHAIR/BASE	PA	90% of MSRP	
K0009	NU	SC	OTHER MANUAL WHEELCHAIR/BASE	PA	90% of MSRP	
K0013	RB		CUSTOM POWER WHLCHR BASE	CMN	95% of MSRP	
K0013	RB	SC	CUSTOM POWER WHLCHR BASE	CMN	95% of MSRP	
K0013	NU		CUSTOM POWER WHLCHR BASE	PA	95% of MSRP	
K0013	NU	SC	CUSTOM POWER WHLCHR BASE	PA	95% of MSRP	
K0015	RB		DETACHABLE, NON-ADJUSTABLE HEIGHT ARMREST; EACH			
K0015	NU		DETACHABLE, NON-ADJUSTABLE HEIGHT ARMREST; EACH			
K0015	RB	SC	DETACHABLE, NON-ADJUSTABLE HEIGHT ARMREST; EACH	MNF		
K0017	RB		DETACH ADJUST ARMREST BASE	CMN		
K0017	RB	SC	DETACH ADJUST ARMREST BASE	CMN		
K0017	NU		DETACH ADJUST ARMREST BASE	CMN		
K0018	RB	SC	DETACH ADJUST ARMRST UPPER	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
K0018	NU		DETACH ADJUST ARMRST UPPER	CMN		
K0018	RB		DETACH ADJUST ARMRST UPPER	CMN		
K0019	RB		ARM PAD REPL, EACH	CMN		
K0019	RB	SC	ARM PAD REPL, EACH	CMN		
K0019	NU		ARM PAD REPL, EACH	CMN		
K0020	RB		FIXED ADJUSTABLE HEIGHT ARMREST; PAIR	CMN		
K0020	RB	SC	FIXED ADJUSTABLE HEIGHT ARMREST; PAIR	CMN		
K0020	NU		FIXED, ADJUSTABLE HEIGHT ARMREST; PAIR	CMN		
K0020	NU	SC	FIXED ADJUSTABLE HEIGHT ARMREST; PAIR	PA		
K0037	RB		HI MOUNT FLIP-UP FTREST REPL	CMN		
K0037	RB	SC	HI MOUNT FLIP-UP FTREST REPL	CMN		
K0037	NU		HI MOUNT FLIP-UP FTREST REPL	CMN		
K0037	NU	SC	HI MOUNT FLIP-UP FTREST REPL	PA		
K0038	RB		LEG STRAP; EACH	CMN		
K0038	RB	SC	LEG STRAP; EACH	CMN		
K0038	NU		LEG STRAP, EACH	CMN		
K0038	NU	SC	LEG STRAP; EACH	PA		
K0039	RB		LEG STRAP H STYLE; EACH	CMN		
K0039	RB	SC	LEG STRAP H STYLE; EACH	CMN		
K0039	NU		LEG STRAP, H STYLE; EACH	CMN		
K0039	NU	SC	LEG STRAP H STYLE; EACH	PA		
K0040	NU		ADJUSTABLE ANGLE FOOTPLATE; EACH	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
K0040	RB		ADJUSTABLE ANGLE FOOTPLATE; EACH	CMN		
K0040	RB	SC	ADJUSTABLE ANGLE FOOTPLATE; EACH	CMN		
K0040	NU	SC	ADJUSTABLE ANGLE FOOTPLATE; EACH	PA		
K0041	RB		LARGE SIZE FOOTPLATE; EACH	CMN		
K0041	RB	SC	LARGE SIZE FOOTPLATE; EACH	CMN		
K0041	NU		LARGE SIZE FOOTPLATE; EACH	CMN		
K0041	NU	SC	LARGE SIZE FOOTPLATE; EACH	PA		
K0042	RB		STANDARD SIZE FTPLATE REP EA	CMN		
K0042	RB	SC	STANDARD SIZE FTPLATE REP EA	CMN		
K0042	NU		STANDARD SIZE FTPLATE REP EA	CMN		
K0043	RB		FTRST LOWR EXTEN TUBE REP EA	CMN		
K0043	RB	SC	FTRST LOWR EXTEN TUBE REP EA	CMN		
K0043	NU		FTRST LOWR EXTEN TUBE REP EA	CMN		
K0044	RB		FTRST UPR HANGER BRAC REP EA	CMN		
K0044	RB	SC	FTRST UPR HANGER BRAC REP EA	CMN		
K0044	NU		FTRST UPR HANGER BRAC REP EA	CMN		
K0045	RB		FTRST COMPL ASSEMBLY REPL EA	CMN		
K0045	RB	SC	FTRST COMPL ASSEMBLY REPL EA	CMN		
K0046	RB		ELEV LGRST LWR EXTEN REPL EA	CMN		
K0046	RB	SC	ELEV LGRST LWR EXTEN REPL EA	CMN		
K0046	NU		ELEV LGRST LWR EXTEN REPL EA	CMN		
K0047	RB		ELEV LEGRST UPR HANGR REP EA	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
K0047	RB	SC	ELEV LEGRST UPR HANGR REP EA	CMN		
K0047	NU		ELEV LEGRST UPR HANGR REP EA	CMN		
K0050	RB		RATCHET ASSEMBLY REPLACEMENT	CMN		
K0050	RB	SC	RATCHET ASSEMBLY REPLACEMENT	CMN		
K0050	NU		RATCHET ASSEMBLY REPLACEMENT	CMN		
K0050	NU	SC	RATCHET ASSEMBLY REPLACEMENT	PA		
K0051	RB		CAM REL ASM FT/LEGRST REP EA	CMN		
K0051	RB	SC	CAM REL ASM FT/LEGRST REP EA	CMN		
K0051	NU		CAM REL ASM FT/LEGRST REP EA	CMN		
K0051	NU	SC	CAM REL ASM FT/LEGRST REP EA	PA		
K0052	RB		SWINGAWAY DETACH FTREST REPL	CMN		
K0052	RB	SC	SWINGAWAY DETACH FTREST REPL	CMN		
K0052	NU		SWINGAWAY DETACH FTREST REPL	CMN		
K0053	RB		ELEVATING FOOT RESTS ARTICULATING (TELESCOPING); EACH	CMN		
K0053	RB	SC	ELEVATING FOOT RESTS ARTICULATING (TELESCOPING); EACH	CMN		
K0053	NU		ELEVATING FOOT RESTS, ARTICULATING (TELESCOPING), EACH	CMN		
K0053	NU	SC	ELEVATING FOOT RESTS ARTICULATING (TELESCOPING); EACH	PA		
K0056	RB		SEAT HT LESS THAN 17 OR EQUAL TO/GREATER THAN 21 FOR HIGH STRENGTH LT WT/ULTRA LT WT W/C'	CMN		
K0056	RB	SC	SEAT HT LESS THAN 17 OR EQUAL TO/GREATER THAN 21 FOR HIGH STRENGTH LT WT/ULTRA LT WT W/C'	CMN		
K0056	NU		SEAT HT.LESS THAN 17 OR EQUAL TO/GREATER THAN 21 FOR HIGH STRENGTH, LT WT/ULTRA-LT WT WHEELCHAIR	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
K0056	NU	SC	SEAT HT LESS THAN 17 OR EQUAL TO/GREATER THAN 21 FOR HIGH STRENGTH LT WT/ULTRA LT WT W/C'	PA		
K0065	RB		SPOKE PROTECTORS; EACH	CMN		
K0065	RB	SC	SPOKE PROTECTORS; EACH	CMN		
K0065	NU		SPOKE PROTECTORS; EACH	CMN		
K0065	NU	SC	SPOKE PROTECTORS; EACH	PA		
K0069	RB		RR WHL COMPL SOL TIRE REP EA	CMN		
K0069	RB	SC	RR WHL COMPL SOL TIRE REP EA	CMN		
K0069	NU		RR WHL COMPL SOL TIRE REP EA	CMN		
K0069	NU	SC	RR WHL COMPL SOL TIRE REP EA	PA		
K0070	RB		REAR WHEEL ASSEMBLY COMPLETE; WITH PNEUMATIC TIRE SPOKE OR MOLDED; EACH	CMN		
K0070	RB	SC	REAR WHEEL ASSEMBLY COMPLETE; WITH PNEUMATIC TIRE SPOKE OR MOLDED; EACH	CMN		
K0070	NU		REAR WHEEL ASSEMBLY,COMPLETE; WITH PNEUMATIC TIRE,SPOKES OR MOLDED; EACH	CMN		
K0070	NU	SC	REAR WHEEL ASSEMBLY COMPLETE; WITH PNEUMATIC TIRE SPOKE OR MOLDED; EACH	PA		
K0071	RB		FR CSTR COMP PNE TIRE REP EA	CMN		
K0071	RB	SC	FR CSTR COMP PNE TIRE REP EA	CMN		
K0071	NU		FR CSTR COMP PNE TIRE REP EA	CMN		
K0071	NU	SC	FR CSTR COMP PNE TIRE REP EA	PA		
K0072	RB		FR CSTR SEMI-PNE TIRE REP EA	CMN		
K0072	RB	SC	FR CSTR SEMI-PNE TIRE REP EA	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
K0072	NU		FR CSTR SEMI-PNE TIRE REP EA	CMN		
K0072	NU	SC	FR CSTR SEMI-PNE TIRE REP EA	PA		
K0073	RB		CASTER PIN LOCK; EACH	CMN		
K0073	RB	SC	CASTER PIN LOCK; EACH	CMN		
K0073	NU		CASTER PIN LOCK; EACH	CMN		
K0073	NU	SC	CASTER PIN LOCK; EACH	PA		
K0077	RB		FR CSTR ASMB SOL TIRE REP EA	CMN		
K0077	RB	SC	FR CSTR ASMB SOL TIRE REP EA	CMN		
K0077	NU		FR CSTR ASMB SOL TIRE REP EA	CMN		
K0077	NU	SC	FR CSTR ASMB SOL TIRE REP EA	PA		
K0098	RB		DRIVE BELT FOR PWC, REPL	CMN		
K0098	RB	SC	DRIVE BELT FOR PWC, REPL	CMN		
K0098	NU		DRIVE BELT FOR PWC, REPL	CMN		
K0098	NU	SC	DRIVE BELT FOR PWC, REPL	PA		
K0105	RB		IV HANGER; EACH	CMN		
K0105	RB	SC	IV HANGER; EACH	CMN		
K0105	NU		IV HANGER; EACH	CMN		
K0105	NU	SC	IV HANGER; EACH	PA		
K0108	RB		WHEELCHAIR COMPONENT OR ACCESSORY NOS	PA	MSRP	
K0108	RB	SC	WHEELCHAIR COMPONENT OR ACCESSORY NOS	PA	MSRP	
K0108	NU		WHEELCHAIR COMPONENT OR ACCESSORY NOS	PA	MSRP	
K0108	NU	SC	WHEELCHAIR COMPONENT OR ACCESSORY NOS	PA	MSRP	

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
K0108	RR		WHEELCHAIR COMPONENT OR ACCESSORY NOS	PA	MSRP	
K0108	RR	SC	WHEELCHAIR COMPONENT OR ACCESSORY NOS	PA	MSRP	
K0195	RR		ELEVATING LEGREST, PAIR (FOR USE WITH RENTAL WHEELCHAIR BASE)	CMN		
K0195	RR	SC	ELEVATING LEG REST, PAIR (FOR USE WITH RENTAL W/C BASE)	PA		
K0603	NU		REPLACE BATTERY 1.5V	MNF		
K0669	NU		SEAT/BACK CUS NO DMEPDAC VER	PA	MSRP	
K0672	NU		ADDITION TO LOWER EXTREMITY ORTHOSIS, REMOVABLE SOFT INTERFACE, ALL COMPONENTS	CMN		
K0730	RR		CTRL DOSE INH DURG DELIV SYS			
K0730	NU		CTRL DOSE INH DRUG DELIV SYS			
K0733	RB		PWC 12 TO 24 AMP HOUR SEALED LEAD ACID BATTERY (EG, GELL CELL, ABSORB)	CMN		
K0733	RB	SC	PWC 12 TO 24 AMP HOUR SEALED LEAD ACID BATTERY (EG, GELL CELL, ABSORB)	CMN		
K0733	NU		POWER WHEELCHAIR ACCESSORY, 12 TO 24 AMP HOUR SEALED LEAD ACID BATTERY, EACH (EG, GEL CELL, ABSORB	CMN		
K0733	NU	SC	PWC 12 TO 24 AMP HOUR SEALED LEAD ACID BATTERY (EG, GELL CELL, ABSORB)	PA		
K0738	RR		PORTABLE GAS OXYGEN SYSTEM	PC		CONTINUOUS RENTAL
K0739	RB		REPAIR/SVC DME NON-OXYGEN EQ	CMN		
K0739	RB	SC	REPAIR/SVC DME NON-OXYGEN EQ	CMN		
K0800	RB		POV GROUP 1 STD UP TO 300 LBS	CMN	MSRP	
K0800	RR		POV GROUP 1 STD UP TO 300 LBS	PA		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
K0800	NU		POV GROUP 1 STD UP TO 300 LBS	PA		
K0801	RB		POV GROUP 1 HD 301-450 LBS	CMN	MSRP	
K0801	RR		POV GROUP 1 HD 301-450 LBS	PA		
K0801	NU		POV GROUP 1 HD 301-450 LBS	PA		
K0802	RB		POV GROUP 1 VHD 451-600 LBS	CMN	MSRP	
K0802	RR		POV GROUP 1 VHD 451-600 LBS	PA		
K0802	NU		POV GROUP 1 VHD 451-600 LBS	PA		
K0806	RB		POV GROUP 2 STD UP TO 300 LBS	CMN	MSRP	
K0806	RR		POV GROUP 2 STD UP TO 300 LBS	PA		
K0806	NU		POV GROUP 2 STD UP TO 300 LBS	PA		
K0807	RB		POV GROUP 2 HD 301-450 LBS	CMN	MSRP	
K0807	RR		POV GROUP 2 HD 301-450 LBS	PA		
K0807	NU		POV GROUP 2 HD 301-450 LBS	PA		
K0808	RB		POV GROUP 2 VHD 451-600 LBS	CMN	MSRP	
K0808	RR		POV GROUP 2 VHD 451-600 LBS	PA		
K0808	NU		POV GROUP 2 VHD 451-600 LBS	PA		
K0812	RB		POWER OPERATED VEHICLE NOC	CMN	MSRP	
K0812	NU		POWER OPERATED VEHICLE NOC	PA	MSRP	
K0813	RB		PWC GP 1 STD PORT SEAT/BACK	CMN	MSRP	
K0813	RB	SC	PWC GP 1 STD PORT SEAT/BACK	CMN	MSRP	
K0813	RR		PWC GP 1 STD PORT SEAT/BACK	PA		
K0813	RR	SC	PWC GP 1 STD PORT SEAT/BACK	PA		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
K0813	NU		PWC GP 1 STD PORT SEAT/BACK	PA		
K0813	NU	SC	PWC GP 1 STD PORT SEAT/BACK	PA		
K0814	RB		PWC GP 1 STD PORT CAP CHAIR	CMN	MSRP	
K0814	RB	SC	PWC GP 1 STD PORT CAP CHAIR	CMN	MSRP	
K0814	RR		PWC GP 1 STD PORT CAP CHAIR	PA		
K0814	RR	SC	PWC GP 1 STD PORT CAP CHAIR	PA		
K0814	NU		PWC GP 1 STD PORT CAP CHAIR	PA		
K0814	NU	SC	PWC GP 1 STD PORT CAP CHAIR	PA		
K0815	RB		PWC GP 1 STD SEAT/BACK	CMN	MSRP	
K0815	RB	SC	PWC GP 1 STD SEAT/BACK	CMN	MSRP	
K0815	RR		PWC GP 1 STD SEAT/BACK	PA		
K0815	RR	SC	PWC GP 1 STD SEAT/BACK	PA		
K0815	NU		PWC GP 1 STD SEAT/BACK	PA		
K0815	NU	SC	PWC GP 1 STD SEAT/BACK	PA		
K0816	RB		PWC GP 1 STD CAP CHAIR	CMN	MSRP	
K0816	RB	SC	PWC GP 1 STD CAP CHAIR	CMN	MSRP	
K0816	RR		PWC GP 1 STD CAP CHAIR	PA		
K0816	RR	SC	PWC GP 1 STD CAP CHAIR	PA		
K0816	NU		PWC GP 1 STD CAP CHAIR	PA		
K0816	NU	SC	PWC GP 1 STD CAP CHAIR	PA		
K0820	RB		PWC GP 2 STD PORT SEAT/BACK	CMN	MSRP	
K0820	RB	SC	PWC GP 2 STD PORT SEAT/BACK	CMN	MSRP	

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
K0820	RR		PWC GP 2 STD PORT SEAT/BACK	PA		
K0820	RR	SC	PWC GP 2 STD PORT SEAT/BACK	PA		
K0820	NU		PWC GP 2 STD PORT SEAT/BACK	PA		
K0820	NU	SC	PWC GP 2 STD PORT SEAT/BACK	PA		
K0821	RB		PWC GP 2 STD PORT CAP CHAIR	CMN	MSRP	
K0821	RB	SC	PWC GP 2 STD PORT CAP CHAIR	CMN	MSRP	
K0821	RR		PWC GP 2 STD PORT CAP CHAIR	PA		
K0821	RR	SC	PWC GP 2 STD PORT CAP CHAIR	PA		
K0821	NU		PWC GP 2 STD PORT CAP CHAIR	PA		
K0821	NU	SC	PWC GP 2 STD PORT CAP CHAIR	PA		
K0822	RB		PWC GP 2 STD SEAT/BACK	CMN	MSRP	
K0822	RB	SC	PWC GP 2 STD SEAT/BACK	CMN	MSRP	
K0822	RR		PWC GP 2 STD SEAT/BACK	PA		
K0822	RR	SC	PWC GP 2 STD SEAT/BACK	PA		
K0822	NU		PWC GP 2 STD SEAT/BACK	PA		
K0822	NU	SC	PWC GP 2 STD SEAT/BACK	PA		
K0823	RB		PWC GP 2 STD CAP CHAIR	CMN	MSRP	
K0823	RB	SC	PWC GP 2 STD CAP CHAIR	CMN	MSRP	
K0823	RR		PWC GP 2 STD CAP CHAIR	PA		12 MONTH RENT TO PURCHASE
K0823	RR	SC	PWC GP 2 STD CAP CHAIR	PA		12 MONTH RENT TO PURCHASE

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
K0823	NU		PWC GP 2 STD CAP CHAIR	PA		
K0823	NU	SC	PWC GP 2 STD CAP CHAIR	PA		
K0824	RB		PWC GP 2 HD SEAT/BACK	CMN	MSRP	
K0824	RB	SC	PWC GP 2 HD SEAT/BACK	CMN	MSRP	
K0824	RR		PWC GP 2 HD SEAT/BACK	PA		
K0824	RR	SC	PWC GP 2 HD SEAT/BACK	PA		
K0824	NU		PWC GP 2 HD SEAT/BACK	PA		
K0824	NU	SC	PWC GP 2 HD SEAT/BACK	PA		
K0825	RB		PWC GP 2 HD CAP CHAIR	CMN	MSRP	
K0825	RB	SC	PWC GP 2 HD CAP CHAIR	CMN	MSRP	
K0825	RR		PWC GP 2 HD CAP CHAIR	PA		
K0825	RR	SC	PWC GP 2 HD CAP CHAIR	PA		
K0825	NU		PWC GP 2 HD CAP CHAIR	PA		
K0825	NU	SC	PWC GP 2 HD CAP CHAIR	PA		
K0826	RB		PWC GP 2 VHD SEAT/BACK	CMN	MSRP	
K0826	RB	SC	PWC GP 2 VHD SEAT/BACK	CMN	MSRP	
K0826	RR		PWC GP 2 VHD SEAT/BACK	PA		
K0826	RR	SC	PWC GP 2 VHD SEAT/BACK	PA		
K0826	NU		PWC GP 2 VHD SEAT/BACK	PA		
K0826	NU	SC	PWC GP 2 VHD SEAT/BACK	PA		
K0827	RB		PWC GP VHD CAP CHAIR	CMN	MSRP	
K0827	RB	SC	PWC GP VHD CAP CHAIR	CMN	MSRP	

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
K0827	RR		PWC GP VHD CAP CHAIR	PA		
K0827	RR	SC	PWC GP VHD CAP CHAIR	PA		
K0827	NU		PWC GP VHD CAP CHAIR	PA		
K0827	NU	SC	PWC GP VHD CAP CHAIR	PA		
K0828	RB		PWC GP 2 XTRA HD SEAT/BACK	CMN	MSRP	
K0828	RB	SC	PWC GP 2 XTRA HD SEAT/BACK	CMN	MSRP	
K0828	RR		PWC GP 2 XTRA HD SEAT/BACK	PA		
K0828	RR	SC	PWC GP 2 XTRA HD SEAT/BACK	PA		
K0828	NU		PWC GP 2 XTRA HD SEAT/BACK	PA		
K0828	NU	SC	PWC GP 2 XTRA HD SEAT/BACK	PA		
K0829	RB		PWC GP 2 XTRA HD CAP CHAIR	CMN	MSRP	
K0829	RB	SC	PWC GP 2 XTRA HD CAP CHAIR	CMN	MSRP	
K0829	RR		PWC GP 2 XTRA HD CAP CHAIR	PA		
K0829	RR	SC	PWC GP 2 XTRA HD CAP CHAIR	PA		
K0829	NU		PWC GP 2 XTRA HD CAP CHAIR	PA		
K0829	NU	SC	PWC GP 2 XTRA HD CAP CHAIR	PA		
K0835	RB		PWC GP2 STD SING POW OPT S/B	CMN	MSRP	
K0835	RB	SC	PWC GP2 STD SING POW OPT S/B	CMN	MSRP	
K0835	RR		PWC GP2 STD SING POW OPT S/B	PA		
K0835	RR	SC	PWC GP2 STD SING POW OPT S/B	PA		
K0835	NU	SC	PWC GP2 STD SING POW OPT S/B	PA		
K0835	NU		PWC GP2 STD SING POW OPT S/B	PA		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
K0836	RB		PWC GP2 STD SING POW OPT CAP	CMN	MSRP	
K0836	RB	SC	PWC GP2 STD SING POW OPT CAP	CMN	MSRP	
K0836	RR		PWC GP2 STD SING POW OPT CAP	PA		
K0836	RR	SC	PWC GP2 STD SING POW OPT CAP	PA		
K0836	NU		PWC GP2 STD SING POW OPT CAP	PA		
K0836	NU	SC	PWC GP2 STD SING POW OPT CAP	PA		
K0837	RB		PWC GP 2 HD SING POW OPT S/B	CMN	MSRP	
K0837	RB	SC	PWC GP 2 HD SING POW OPT S/B	CMN	MSRP	
K0837	RR		PWC GP 2 HD SING POW OPT S/B	PA		
K0837	RR	SC	PWC GP 2 HD SING POW OPT S/B	PA		
K0837	NU		PWC GP 2 HD SING POW OPT S/B	PA		
K0837	NU	SC	PWC GP 2 HD SING POW OPT S/B	PA		
K0838	RB		PWC GP 2 HD SING POW OPT CAP	CMN	MSRP	
K0838	RB	SC	PWC GP 2 HD SING POW OPT CAP	CMN	MSRP	
K0838	RR		PWC GP 2 HD SING POW OPT CAP	PA		
K0838	RR	SC	PWC GP 2 HD SING POW OPT CAP	PA		
K0838	NU		PWC GP 2 HD SING POW OPT CAP	PA		
K0838	NU	SC	PWC GP 2 HD SING POW OPT CAP	PA		
K0839	RB		PWC GP2 VHD SING POW OPT S/B	CMN	MSRP	
K0839	RB	SC	PWC GP2 VHD SING POW OPT S/B	CMN	MSRP	
K0839	RR		PWC GP2 VHD SING POW OPT S/B	PA		
K0839	RR	SC	PWC GP2 VHD SING POW OPT S/B	PA		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
K0839	NU		PWC GP2 VHD SING POW OPT S/B	PA		
K0839	NU	SC	PWC GP2 VHD SING POW OPT S/B	PA		
K0840	RB		PWC GP2 XHD SING POW OPT S/B	CMN	MSRP	
K0840	RB	SC	PWC GP2 XHD SING POW OPT S/B	CMN	MSRP	
K0840	RR		PWC GP2 XHD SING POW OPT S/B	PA		
K0840	RR	SC	PWC GP2 XHD SING POW OPT S/B	PA		
K0840	NU		PWC GP2 XHD SING POW OPT S/B	PA		
K0840	NU	SC	PWC GP2 XHD SING POW OPT S/B	PA		
K0841	RB		PWC GP2 STD MULT POW OPT S/B	CMN	MSRP	
K0841	RB	SC	PWC GP2 STD MULT POW OPT S/B	CMN	MSRP	
K0841	RR		PWC GP2 STD MULT POW OPT S/B	PA		
K0841	RR	SC	PWC GP2 STD MULT POW OPT S/B	PA		
K0841	NU		PWC GP2 STD MULT POW OPT S/B	PA		
K0841	NU	SC	PWC GP2 STD MULT POW OPT S/B	PA		
K0842	RB		PWC GP2 STD MULT POW OPT CAP	CMN	MSRP	
K0842	RB	SC	PWC GP2 STD MULT POW OPT CAP	CMN	MSRP	
K0842	RR		PWC GP2 STD MULT POW OPT CAP	PA		
K0842	RR	SC	PWC GP2 STD MULT POW OPT CAP	PA		
K0842	NU		PWC GP2 STD MULT POW OPT CAP	PA		
K0842	NU	SC	PWC GP2 STD MULT POW OPT CAP	PA		
K0843	RB		PWC GP2 HD MULT POW OPT S/B	CMN	MSRP	
K0843	RB	SC	PWC GP2 HD MULT POW OPT S/B	CMN	MSRP	

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
K0843	RR		PWC GP2 HD MULT POW OPT S/B	PA		
K0843	RR	SC	PWC GP2 HD MULT POW OPT S/B	PA		
K0843	NU		PWC GP2 HD MULT POW OPT S/B	PA		
K0843	NU	SC	PWC GP2 HD MULT POW OPT S/B	PA		
K0848	RB		PWC GP 3 STD SEAT/BACK	CMN	MSRP	
K0848	RB	SC	PWC GP 3 STD SEAT/BACK	CMN	MSRP	
K0848	RR		PWC GP 3 STD SEAT/BACK	PA		
K0848	RR	SC	PWC GP 3 STD SEAT/BACK	PA		
K0848	NU		PWC GP 3 STD SEAT/BACK	PA		
K0848	NU	SC	PWC GP 3 STD SEAT/BACK	PA		
K0849	RB		PWC GP 3 STD CAP CHAIR	CMN	MSRP	
K0849	RB	SC	PWC GP 3 STD CAP CHAIR	CMN	MSRP	
K0849	RR		PWC GP 3 STD CAP CHAIR	PA		
K0849	RR	SC	PWC GP 3 STD CAP CHAIR	PA		
K0849	NU		PWC GP 3 STD CAP CHAIR	PA		
K0849	NU	SC	PWC GP 3 STD CAP CHAIR	PA		
K0850	RB		PWC GP 3 HD SEAT/BACK	CMN	MSRP	
K0850	RB	SC	PWC GP 3 HD SEAT/BACK	CMN	MSRP	
K0850	RR		PWC GP 3 HD SEAT/BACK	PA		
K0850	RR	SC	PWC GP 3 HD SEAT/BACK	PA		
K0850	NU		PWC GP 3 HD SEAT/BACK	PA		
K0850	NU	SC	PWC GP 3 HD SEAT/BACK	PA		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
K0851	RB		PWC GP 3 HD CAP CHAIR	CMN	MSRP	
K0851	RB	SC	PWC GP 3 HD CAP CHAIR	CMN	MSRP	
K0851	RR		PWC GP 3 HD CAP CHAIR	PA		
K0851	RR	SC	PWC GP 3 HD CAP CHAIR	PA		
K0851	NU		PWC GP 3 HD CAP CHAIR	PA		
K0851	NU	SC	PWC GP 3 HD CAP CHAIR	PA		
K0852	RB		PWC GP 3 VHD SEAT/BACK	CMN	MSRP	
K0852	RB	SC	PWC GP 3 VHD SEAT/BACK	CMN	MSRP	
K0852	RR		PWC GP 3 VHD SEAT/BACK	PA		
K0852	RR	SC	PWC GP 3 VHD SEAT/BACK	PA		
K0852	NU		PWC GP 3 VHD SEAT/BACK	PA		
K0852	NU	SC	PWC GP 3 VHD SEAT/BACK	PA		
K0853	RB		PWC GP 3 VHD CAP CHAIR	CMN	MSRP	
K0853	RB	SC	PWC GP 3 VHD CAP CHAIR	CMN	MSRP	
K0853	RR		PWC GP 3 VHD CAP CHAIR	PA		
K0853	RR	SC	PWC GP 3 VHD CAP CHAIR	PA		
K0853	NU		PWC GP 3 VHD CAP CHAIR	PA		
K0853	NU	SC	PWC GP 3 VHD CAP CHAIR	PA		
K0854	RB		PWC GP 3 XHD SEAT/BACK	CMN	MSRP	
K0854	RB	SC	PWC GP 3 XHD SEAT/BACK	CMN	MSRP	
K0854	RR		PWC GP 3 XHD SEAT/BACK	PA		
K0854	RR	SC	PWC GP 3 XHD SEAT/BACK	PA		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
K0854	NU	SC	PWC GP 3 XHD SEAT/BACK	PA		
K0854	NU		PWC GP 3 XHD SEAT/BACK	PA		
K0855	RB		PWC GP 3 XHD CAP CHAIR	CMN	MSRP	
K0855	RB	SC	PWC GP 3 XHD CAP CHAIR	CMN	MSRP	
K0855	RR		PWC GP 3 XHD CAP CHAIR	PA		
K0855	RR	SC	PWC GP 3 XHD CAP CHAIR	PA		
K0855	NU		PWC GP 3 XHD CAP CHAIR	PA		
K0855	NU	SC	PWC GP 3 XHD CAP CHAIR	PA		
K0856	RB		PWC GP3 STD SING POW OPT S/B	CMN	MSRP	
K0856	RB	SC	PWC GP3 STD SING POW OPT S/B	CMN	MSRP	
K0856	RR		PWC GP3 STD SING POW OPT S/B	PA		
K0856	RR	SC	PWC GP3 STD SING POW OPT S/B	PA		
K0856	NU		PWC GP3 STD SING POW OPT S/B	PA		
K0856	NU	SC	PWC GP3 STD SING POW OPT S/B	PA		
K0857	RB		PWC GP3 STD SING POW OPT CAP	CMN	MSRP	
K0857	RB	SC	PWC GP3 STD SING POW OPT CAP	CMN	MSRP	
K0857	RR		PWC GP3 STD SING POW OPT CAP	PA		
K0857	RR	SC	PWC GP3 STD SING POW OPT CAP	PA		
K0857	NU		PWC GP3 STD SING POW OPT CAP	PA		
K0857	NU	SC	PWC GP3 STD SING POW OPT CAP	PA		
K0858	RB		PWC GP3 HD SING POW OPT S/B	CMN	MSRP	
K0858	RB	SC	PWC GP3 HD SING POW OPT S/B	CMN	MSRP	

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
K0858	RR		PWC GP3 HD SING POW OPT S/B	PA		
K0858	RR	SC	PWC GP3 HD SING POW OPT S/B	PA		
K0858	NU		PWC GP3 HD SING POW OPT S/B	PA		
K0858	NU	SC	PWC GP3 HD SING POW OPT S/B	PA		
K0859	RB		PWC GP3 HD SING POW OPT CAP	CMN	MSRP	
K0859	RB	SC	PWC GP3 HD SING POW OPT CAP	CMN	MSRP	
K0859	RR		PWC GP3 HD SING POW OPT CAP	PA		
K0859	RR	SC	PWC GP3 HD SING POW OPT CAP	PA		
K0859	NU		PWC GP3 HD SING POW OPT CAP	PA		
K0859	NU	SC	PWC GP3 HD SING POW OPT CAP	PA		
K0860	RB		PWC GP3 VHD SING POW OPT S/B	CMN	MSRP	
K0860	RB	SC	PWC GP3 VHD SING POW OPT S/B	CMN	MSRP	
K0860	RR		PWC GP3 VHD SING POW OPT S/B	PA		
K0860	RR	SC	PWC GP3 VHD SING POW OPT S/B	PA		
K0860	NU		PWC GP3 VHD SING POW OPT S/B	PA		
K0860	NU	SC	PWC GP3 VHD SING POW OPT S/B	PA		
K0861	RB		PWC GP3 STD MULT POW OPT S/B	CMN	MSRP	
K0861	RB	SC	PWC GP3 STD MULT POW OPT S/B	CMN	MSRP	
K0861	RR		PWC GP3 STD MULT POW OPT S/B	PA		
K0861	RR	SC	PWC GP3 STD MULT POW OPT S/B	PA		
K0861	NU		PWC GP3 STD MULT POW OPT S/B	PA		
K0861	NU	SC	PWC GP3 STD MULT POW OPT S/B	PA		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
K0862	RB		PWC GP3 HD MULT POW OPT S/B	CMN	MSRP	
K0862	RB	SC	PWC GP3 HD MULT POW OPT S/B	CMN	MSRP	
K0862	RR		PWC GP3 HD MULT POW OPT S/B	PA		
K0862	RR	SC	PWC GP3 HD MULT POW OPT S/B	PA		
K0862	NU		PWC GP3 HD MULT POW OPT S/B	PA		
K0862	NU	SC	PWC GP3 HD MULT POW OPT S/B	PA		
K0863	RB		PWC GP3 VHD MULT POW OPT S/B	CMN	MSRP	
K0863	RB	SC	PWC GP3 VHD MULT POW OPT S/B	CMN	MSRP	
K0863	RR		PWC GP3 VHD MULT POW OPT S/B	PA		
K0863	RR	SC	PWC GP3 VHD MULT POW OPT S/B	PA		
K0863	NU		PWC GP3 VHD MULT POW OPT S/B	PA		
K0863	NU	SC	PWC GP3 VHD MULT POW OPT S/B	PA		
K0864	RB		PWC GP3 XHD MULT POW OPT S/B	CMN	MSRP	
K0864	RB	SC	PWC GP3 XHD MULT POW OPT S/B	CMN	MSRP	
K0864	RR		PWC GP3 XHD MULT POW OPT S/B	PA		
K0864	RR	SC	PWC GP3 XHD MULT POW OPT S/B	PA		
K0864	NU		PWC GP3 XHD MULT POW OPT S/B	PA		
K0864	NU	SC	PWC GP3 XHD MULT POW OPT S/B	PA		
K0868	RB		PWC GP 4 STD SEAT/BACK	CMN	MSRP	
K0868	RB	SC	PWC GP 4 STD SEAT/BACK	CMN	MSRP	
K0868	NU		PWC GP 4 STD SEAT/BACK	PA	MSRP	
K0868	NU	SC	PWC GP 4 STD SEAT/BACK	PA	MSRP	

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
K0869	RB		PWC GP 4 STD CAP CHAIR	CMN	MSRP	
K0869	RB	SC	PWC GP 4 STD CAP CHAIR	CMN	MSRP	
K0869	NU		PWC GP 4 STD CAP CHAIR	PA	MSRP	
K0869	NU	SC	PWC GP 4 STD CAP CHAIR	PA	MSRP	
K0870	RB		PWC GP 4 HD SEAT/BACK	CMN	MSRP	
K0870	RB	SC	PWC GP 4 HD SEAT/BACK	CMN	MSRP	
K0870	NU		PWC GP 4 HD SEAT/BACK	PA	MSRP	
K0870	NU	SC	PWC GP 4 HD SEAT/BACK	PA	MSRP	
K0871	RB		PWC GP 4 VHD SEAT/BACK	CMN	MSRP	
K0871	RB	SC	PWC GP 4 VHD SEAT/BACK	CMN	MSRP	
K0871	NU		PWC GP 4 VHD SEAT/BACK	PA	MSRP	
K0871	NU	SC	PWC GP 4 VHD SEAT/BACK	PA	MSRP	
K0877	RB		PWC GP4 STD SING POW OPT S/B	CMN	MSRP	
K0877	RB	SC	PWC GP4 STD SING POW OPT S/B	CMN	MSRP	
K0877	NU		PWC GP4 STD SING POW OPT S/B	PA	MSRP	
K0877	NU	SC	PWC GP4 STD SING POW OPT S/B	PA	MSRP	
K0878	RB		PWC GP4 STD SING POW OPT CAP	CMN	MSRP	
K0878	RB	SC	PWC GP4 STD SING POW OPT CAP	CMN	MSRP	
K0878	NU		PWC GP4 STD SING POW OPT CAP	PA	MSRP	
K0878	NU	SC	PWC GP4 STD SING POW OPT CAP	PA	MSRP	
K0879	RB		PWC GP4 HD SING POW OPT S/B	CMN	MSRP	
K0879	RB	SC	PWC GP4 HD SING POW OPT S/B	CMN	MSRP	

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
K0879	NU		PWC GP4 HD SING POW OPT S/B	PA	MSRP	
K0879	NU	SC	PWC GP4 HD SING POW OPT S/B	PA	MSRP	
K0880	RB		PWC GP4 VHD SING POW OPT S/B	CMN	MSRP	
K0880	RB	SC	PWC GP4 VHD SING POW OPT S/B	CMN	MSRP	
K0880	NU		PWC GP4 VHD SING POW OPT S/B	PA	MSRP	
K0880	NU	SC	PWC GP4 VHD SING POW OPT S/B	PA	MSRP	
K0884	RB		PWC GP4 STD MULT POW OPT S/B	CMN	MSRP	
K0884	RB	SC	PWC GP4 STD MULT POW OPT S/B	CMN	MSRP	
K0884	NU		PWC GP4 STD MULT POW OPT S/B	PA	MSRP	
K0884	NU	SC	PWC GP4 STD MULT POW OPT S/B	PA	MSRP	
K0885	RB		PWC GP4 STD MULT POW OPT CAP	CMN	MSRP	
K0885	RB	SC	PWC GP4 STD MULT POW OPT CAP	CMN	MSRP	
K0885	NU		PWC GP4 STD MULT POW OPT CAP	PA	MSRP	
K0885	NU	SC	PWC GP4 STD MULT POW OPT CAP	PA	MSRP	
K0886	RB		PWC GP4 HD MULT POW S/B	CMN	MSRP	
K0886	RB	SC	PWC GP4 HD MULT POW S/B	CMN	MSRP	
K0886	NU		PWC GP4 HD MULT POW S/B	PA	MSRP	
K0886	NU	SC	PWC GP4 HD MULT POW S/B	PA	MSRP	
K0890	RB		PWC GP5 PED SING POW OPT S/B	CMN	MSRP	
K0890	RB	SC	PWC GP5 PED SING POW OPT S/B	CMN	MSRP	
K0890	NU		PWC GP5 PED SING POW OPT S/B	PA	MSRP	
K0890	NU	SC	PWC GP5 PED SING POW OPT S/B	PA	MSRP	

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
K0891	RB		PWC GP5 PED MULT POW OPT S/B	CMN	MSRP	
K0891	RB	SC	PWC GP5 PED MULT POW OPT S/B	CMN	MSRP	
K0891	NU		PWC GP5 PED MULT POW OPT S/B	PA	MSRP	
K0891	NU	SC	PWC GP5 PED MULT POW OPT S/B	PA	MSRP	
K0898	RB		POWER WHEELCHAIR NOC	CMN	MSRP	
K0898	RB	SC	POWER WHEELCHAIR NOC	CMN	MSRP	
K0898	NU		POWER WHEELCHAIR NOC	PA	MSRP	
K0898	NU	SC	POWER WHEELCHAIR NOC	PA	MSRP	
K0900	RB		CSTM DME OTHER THAN WHEELCHR	CMN	MSRP	
K0900	RB	SC	CSTM DME OTHER THAN WHEELCHR	CMN	MSRP	
K0900	NU		CSTM DME OTHER THAN WHEELCHR	PA	MSRP	
K0900	NU	SC	CSTM DME OTHER THAN WHEELCHR	PA	MSRP	
L0120	RB		CERV FLEX N/ADJ FOAM PRE OTS	CMN	IOC	
L0120	NU		CERV FLEX N/ADJ FOAM PRE OTS	CMN		
L0130	RB		CERVICAL, FLEXIBLE, THERMOPLASTIC COLLAR, MOLDED TO PATIENT	CMN	IOC	
L0130	NU		CERVICAL, FLEXIBLE, THERMOPLASTIC COLLAR, MOLDED TO PATIENT	CMN		
L0140	RB		CERVICAL, SEMI-RIGID, ADJUSTABLE (PLASTIC COLLAR)	CMN	IOC	
L0140	NU		CERVICAL, SEMI-RIGID, ADJUSTABLE (PLASTIC COLLAR)	CMN		
L0150	RB		CERVICAL, SEMI-RIGID, ADJUSTABLE MOLDED CHIN CUP (PLASTIC COLLAR WITH MANDIBULAR/OCCIPITAL PIECE)	CMN	IOC	

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L0150	NU		CERVICAL, SEMI-RIGID, ADJUSTABLE MOLDED CHIN CUP (PLASTIC COLLAR WITH MANDIBULAR/OCCIPITAL PIECE)	CMN		
L0160	RB		CERV SR WIRE OCC/MAN PRE OTS	CMN	IOC	
L0160	NU		CERV SR WIRE OCC/MAN PRE OTS	CMN		
L0170	RB		CERVICAL, COLLAR, MOLDED TO PATIENT MODEL	CMN	IOC	
L0170	NU		CERVICAL, COLLAR, MOLDED TO PATIENT MODEL	CMN		
L0172	RB		CERV COL SR FOAM 2PC PRE OTS	CMN	IOC	
L0172	NU		CERV COL SR FOAM 2PC PRE OTS	CMN		
L0174	RB		CERV SR 2PC THOR EXT PRE OTS	CMN	IOC	
L0174	NU		CERV SR 2PC THOR EXT PRE OTS	CMN		
L0180	RB		CERVICAL, MULTIPLE POST COLLAR, OCCIPITAL/MANDIBULAR SUPPORTS, ADJUSTABLE	CMN	IOC	
L0180	NU		CERVICAL, MULTIPLE POST COLLAR, OCCIPITAL/MANDIBULAR SUPPORTS, ADJUSTABLE	CMN		
L0190	RB		CERVICAL, MULTIPLE POST COLLAR, OCCIPITAL/MANDIBULAR SUPPORTS, ADJUSTABLE CERVICAL BARS (SOMI, GUILF	CMN	IOC	
L0190	NU		CERVICAL, MULTIPLE POST COLLAR, OCCIPITAL/MANDIBULAR SUPPORTS, ADJUSTABLE CERVICAL BARS (SOMI, GUILF	CMN		
L0200	RB		CERVICAL, MULTIPLE POST COLLAR, OCCIPITAL/MANDIBULAR SUPPORTS, ADJUSTABLE CERVICAL BARS, AND THORACIC	CMN	IOC	
L0200	NU		CERVICAL, MULTIPLE POST COLLAR, OCCIPITAL/MANDIBULAR SUPPORTS, ADJUST CERVIVAL BARS, AND THORACIC EXT	CMN		
L0220	RB		THORACIC, RIB BELT, CUSTOM FABRICATED	CMN	IOC	
L0220	NU		THORACIC, RIB BELT, CUSTOM FABRICATED	PA		

Procedure Code	Modifiers	Description	Reimbursement Guidelines	Limits Qty/Days and Comments
L0450	NU	TLSO FLEX TRUNK/THOR PRE OTS	CMN	
L0452	NU	TLSO FLEX CUSTOM FAB THORACI	CMN	
L0454	NU	TLSO TRNK SJ-T9 PRE CST	CMN	
L0455	NU	TLSO FLEX TRNK SJ-T9 PRE OTS	CMN	
L0456	NU	TLSO FLEX TRNK SJ-SS PRE CST	CMN	
L0457	NU	TLSO FLEX TRNK SJ-SS PRE OTS	CMN	
L0458	NU	TLSO 2MOD SYMPHIS-XIPHO PRE	CMN	
L0460	NU	TLSO 2 SHL SYMPHYS-STERN CST	CMN	
L0462	NU	TLSO 3MOD SACRO-SCAP PRE	CMN	
L0464	NU	TLSO 4MOD SACRO-SCAP PRE	CMN	
L0466	NU	TLSO R FRAM SOFT ANT PRE CST	CMN	
L0467	NU	TLSO R FRAM SOFT PRE OTS	CMN	
L0468	NU	TLSO RIG FRAM PELVIC PRE CST	CMN	
L0469	NU	TLSO RIG FRAM PELVIC PRE OTS	CMN	
L0470	NU	TLSO RIGID FRAME PRE SUBCLAV	CMN	
L0472	NU	TLSO RIGID FRAME HYPEREX PRE	CMN	
L0480	NU	TLSO RIGID PLASTIC CUSTOM FA	CMN	
L0482	NU	TLSO RIGID LINED CUSTOM FAB	CMN	
L0484	NU	TLSO RIGID PLASTIC CUST FAB	CMN	
L0486	NU	TLSO RIGIDLINED CUST FAB TWO	CMN	
L0488	NU	TLSO RIGID LINED PRE ONE PIE	CMN	
L0490	NU	TLSO RIGID PLASTIC PRE ONE	CMN	

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L0491	NU		TLSO 2-PIECE RIGID SHELL SPINAL SYSTEM	CMN		
L0492	NU		TLSO 3A-PIECE RIGID SHELL SPINAL SYSTEM	CMN		
L0621	NU		SIO FLEX PELVIC/SACR PRE OTS	CMN		
L0622	NU		SIO FLEX PELVISACRAL CUSTOM	CMN		
L0623	NU		SIO RIG PNL PELV/SAC PRE OTS	CMN		
L0624	NU		SIO PANEL CUSTOM	CMN	IOC	
L0625	NU		LO FLEX L1-BELOW L5 PRE OTS	CMN		
L0626	NU		LO SAG RIG PNL STAYS PRE CST	CMN		
L0627	NU		LO SAG RI AN/POS PNL PRE CST	CMN		
L0628	NU		LSO FLEX NO RI STAYS PRE OTS	CMN		
L0629	NU		LSO FLEX W/RIGID STAYS CUST	CMN		
L0630	NU		LSO R POST PNL SJ-T9 PRE CST	CMN		
L0631	NU		LSO SAG R AN/POS PNL PRE CST	CMN		
L0632	NU		LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR	CMN		
L0633	NU		LSO SC R POS/LAT PNL PRE CST	CMN		
L0634	NU		LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID POSTERIOR	CMN		
L0635	NU		LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, LUMBAR FLEXION, RIGID	CMN		
L0636	NU		LUMBAR SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, LUMBAR FLEXION, RIGID	CMN		
L0637	NU		LSO SC R ANT/POS PNL PRE CST	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L0638	NU		LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID ANTERIOR AND	CMN		
L0639	NU		LSO S/C SHELL/PANEL PREFAB	CMN		
L0640	NU		LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, RIGID SHELL(S)/PANEL(S)	CMN		
L0641	NU		LO RIG POS PNL L1-L5 PRE OTS	CMN		
L0642	NU		LO SAG RI AN/POS PNL PRE OTS	CMN		
L0643	NU		LSO SAG CTR RIGI POS PRE OTS	CMN		
L0648	NU		LSO SAG R AN/POS PNL PRE OTS	CMN		
L0649	NU		LSO SC R POS/LAT PNL PRE OTS	CMN		
L0650	NU		LSO SC R ANT/POS PNL PRE OTS	CMN		
L0651	NU		LSO SAG-CO SHELL PNL PRE OTS	CMN		
L0700	RB		CTLSO, ANTERIOR-POSTERIOR-LATERAL CONTROL, MOLDED TO PATIENT	CMN		
L0700	NU		CTLSO, ANTERIOR-POSTERIOR-LATERAL CONTROL, MOLDED TO PATIENT (MINERRA TYPE)	CMN		
L0710	RB		CTLSO, ANTERIOR-POSTERIOR-LATERAL-CONTROL, MOLDED TO PATIENT MODEL, WITH INTERFACE MATERIAL, (MINERV	CMN		
L0710	NU		CTLSO, ANTERIOR-POSTERIOR-LATERAL-CONTROL, MOLDED TO PATIENT MODEL, WITH INTERFACE MATERIAL, (MINERV	CMN		
L0810	RB		HALO PROCEDURE, VEST	CMN	IOC	
L0810	NU		HALO PROCEDURE, CERVICAL INC. INTO JACKET VEST	CMN		
L0820	RB		HALO PROCEDURE, JACKET	CMN	IOC	

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L0820	NU		HALO PROCEDURE, CERVICAL HALO INC INTO PLASTER BODY JACKET	CMN		
L0830	RB		HALO PROCEDURE, ORTHOSIS	CMN	IOC	
L0830	NU		HALO PROCEDURE, CERVICAL HALOINC INTO MILWAUKEE TYPE ORTHOSIS	CMN		
L0859	RB		MRI COMPATIBLE SYSTEM	CMN	IOC	
L0859	NU		MRI COMPATIBLE SYSTEM	CMN		
L0861	NU		HALO REPL LINER/INTERFACE	PA		
L0970	NU		TLSO, CORSET FRONT	CMN		
L0972	NU		LSO, CORSET FRONT	CMN		
L0974	NU		TLSO, FULL CORSET	CMN		
L0976	NU		LSO, FULL CORSET	CMN		
L0978	NU		AXILLARY CRUTCH EXTENSION	CMN		
L0984	NU		PROTECT BODY SOCK EA PRE OTS	CMN		
L0999	NU		ADDITION TO SPINAL ORTHOSIS, NOT OTHERWISE SPECIFIED	PA	IOC	
L1000	RB		CTLSO (MILWAUKEE), INCLUSIVE OF FURNISHING INITIAL ORTHOS	CMN		
L1000	NU		CTLSO (MILWAUKEE), INCLUSIVE OF FURNISHING INITIAL ORTHOSIS, INCLUDING MODEL	CMN		
L1010	NU		ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, AXILLA SLING	CMN		
L1020	NU		ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, KYPHOSIS PAD	CMN		
L1025	NU		ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, KYPHOSIS PAD, FLOATING	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L1030	NU		ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, LUMBAR BOLSTER PAD	CMN		
L1040	NU		ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, LUMBAR OR LUMBAR RIB PAD	CMN		
L1050	NU		ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, STERNAL PAD	CMN		
L1060	NU		ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, THORACIC PAD	CMN		
L1070	NU		ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, TRAPEZE SLING	CMN		
L1080	NU		ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, OUTRIGGER	CMN		
L1085	NU		ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, OUTRIGGER, BILATERAL WITH VERTICAL EXTENSIONS	CMN		
L1090	NU		ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, LUMBAR SLING	CMN		
L1100	NU		ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, RING FLANGE, PLASTIC OR LEATHER	CMN		
L1110	NU		ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, RING FLANGE, PLASTIC OR LEATHER, MOLDED TO PATIENT MODEL	CMN		
L1120	NU		ADDITION TO CTLSO, SCOLIOSIS ORTHOSIS, COVER FOR UPRIGHT, EACH	CMN		
L1200	NU		TLSO, INCLUSIVE OF FURNISHING INITIAL ORTHOSIS ONLY	CMN		
L1210	NU		ADDITION TO TLSO, (LOW PROFILE), LATERAL THORACIC EXTENSION	CMN		
L1220	NU		ADDITION TO TLSO, (LOW PROFILE), ANTERIOR THORACIC EXTENSION	CMN		
L1230	NU		ADDITION TO TLSO, (LOW PROFILE), MILWAUKEE TYPE SUPERSTRUCTURE	CMN		
L1240	NU		ADDITION TO TLSO (LOW PROFILE), LUMBAR DEROTATION PAD	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L1250	NU		ADDITION TO TLSO (LOW PROFILE), ANTERIOR ASIS PAD	CMN		
L1260	NU		ADDITION TO TLSO (LOW PROFILE), ANTERIOR THORACIC DEROTATION PAD	CMN		
L1270	NU		ADDITION TO TLSO (LOW PROFILE), ABDOMINAL PAD	CMN		
L1280	NU		ADDITION TO TLSO (LOW PROFILE), RIB GUSSET (ELASTIC), EACH	CMN		
L1290	NU		ADDITION TO TLSO (LOW PROFILE), LATERAL TROCHANTERIC PAD	CMN		
L1300	RB		OTHER SCOLIOSIS PROCEDURE, BODY JACKET MOLDED TO PATIENT MODEL	CMN		
L1300	NU		OTHER SCOLIOSIS PROCEDURE, BODY JACKET MOLDED TO PATIENT MODEL	CMN		
L1310	RB		OTHER SCOLIOSIS PROCEDURE	CMN	IOC	
L1310	NU		OTHER SCOLIOSIS PROCEDURE, POST OPERATIVE BODY JACKET	CMN		
L1499	NU		SPINAL ORTHOSIS, NOT OTHERWISE SPECIFIED	PA	IOC	
L1600	RB		HO FLEX FREJKA W/COV PRE CST	CMN	IOC	
L1600	NU		HO FLEX FREJKA W/COV PRE CST	CMN		
L1610	RB		HO FREJKA COV ONLY PRE CST	CMN	IOC	
L1610	NU		HO FREJKA COV ONLY PRE CST	CMN		
L1620	RB		HO FLEX PAVLIK HARNS PRE CST	CMN	IOC	
L1620	NU		HO FLEX PAVLIK HARNS PRE CST	CMN		
L1630	RB		HO, ABDUCTION CONTROL OF HIP JOINTS, SEMI-FLEXIBLE (VON ROSEN TYPE)	CMN	IOC	

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L1630	NU		HO, ABDUCTION CONTROL OF HIP JOINTS, SEMI-FLEXIBLE (VON ROSEN TYPE)	CMN		
L1640	RB		HO, ABDUCTION CONTROL OF HIP JOINTS, STATIC, PELVIC BAND OR SPREADER BAR, THIGH CUFFS	CMN	IOC	
L1640	NU		HO, ABDUCTION CONTROL OF HIP JOINTS, STATIC, PELVIC BAND OR SPREADER BAR, THIGH CUFFS	CMN		
L1650	RB		HO, ABDUCTION CONTROL OF HIP JOINTS, STATIC, ADJUSTABLE, (ILFLED TYPE)	CMN	IOC	
L1650	NU		HO, ABDUCTION CONTROL OF HIP JOINTS, STATIC, ADJUSTABLE, (ILFLED TYPE)	CMN		
L1652	NU		HO, BI THIGHCUFFS W SPRDR BAR	CMN		
L1660	RB		HO, ABDUCTION CONTROL OF HIP JOINTS, STATIC, PLASTIC,	CMN	IOC	
L1660	NU		HO, ABDUCTION CONTROL OF HIP JOINTS, STATIC, PLASTIC,PREFABRICATED,INCLUDES FITTING & ADJUSTMENTS	CMN		
L1680	RB		HO, ABDUCTION CONTROL OF HIP JOINTS, DYNAMIC, PELVIC CONTROL, ADJUSTABLE HIP MOTION CONTROL, THIGH C	CMN	IOC	
L1680	NU		HO, ABDUCTION CONTROL OF HIP JOINTS, DYNAMIC, PELVIC CONTROL, ADJUST HIP MOTION CONTROL, THIGH CUFFS	CMN		
L1685	RB		HO, ABDUCTION CONTROL OF HIP JOINT, POST-OPERATIVE HIP ABDUCTION TYPE, CUSTOM FABRICATED	CMN	IOC	
L1685	NU		HO, ABDUCTION CONTROL OF HIP JOINT, POST-OPERATIVE HIP ABDUCTION TYPE, CUSTOM FABRICATED	CMN		
L1686	RB		HO, ABDUCTION CONTROL OF HIP JOINT, POST-OPERATIVE HIP ABDUCTION TYPE	CMN	IOC	
L1686	NU		HO, POST-OPERATIVE HIP ABDUCTION TYPE,PREFABRICATED, INCLUDES FITTING & ADJUSTMENTS	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L1690	NU		COMBINATION,BILATERAL,LUMBO-SACRAL,HIP,FEMUR, ORTHOSIS PROVIDING ADDUCTION & INTERNAL ROTATION CONTROL	CMN		
L1700	RB		LEGG PERTHES ORTHOSIS, TORONTO TYPE	CMN	IOC	
L1700	NU		LEGG PERTHES ORTHOSIS, TORONTO TYPE	CMN		
L1710	RB		LEGG PERTHES ORTHOSIS, NEWINGTON TYPE	CMN	IOC	
L1710	NU		LEGG PERTHES ORTHOSIS, NEWINGTON TYPE	CMN		
L1720	RB		LEGG PERTHES ORTHOSIS, TRILATERAL, (TACHDIJAN TYPE)	CMN	IOC	
L1720	NU		LEGG PERTHES ORTHOSIS, TRILATERAL, (TACHDIJAN TYPE)	CMN		
L1730	RB		LEGG PERTHES ORTHOSIS, SCOTTISH RITE TYPE	CMN	IOC	
L1730	NU		LEGG PERTHES ORTHOSIS, SCOTTISH RITE TYPE	CMN		
L1755	RB		LEGG PERTHES ORTHOSIS, PATTEN BOTTOM TYPE	CMN	IOC	
L1755	NU		LEGG PERTHES PATTEN BOTTOM TYPE, CUDTOM FABRICATED	CMN		
L1810	RB		KO ELASTIC WITH JOINTS	CMN	IOC	
L1810	NU		KO ELASTIC WITH JOINTS	CMN		
L1812	NU		KO ELASTIC W/JOINTS PRE OTS	CMN		
L1820	RB		KNEE ORTHOSIS, ELASTIC WITH CONDYLAR PADS/JOINTS W/WO PATELLAR	CMN	IOC	
L1820	NU		KNEE ORTHOSIS, ELASTIC WITH CONDYLAR PADS/JOINTS W/WO PATELLAR	CMN		
L1830	RB		KO IMMOB CANVAS LONG PRE OTS	CMN	IOC	
L1830	NU		KO IMMOB CANVAS LONG PRE OTS	CMN		
L1831	NU		KNEE ORTH POS LOCKING JOINT	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L1832	RB		KO ADJ JNT POS R SUP PRE CST	CMN	IOC	
L1832	NU		KO ADJ JNT POS R SUP PRE CST	CMN		
L1833	NU		KO ADJ JNT POS R SUP PRE OTS	CMN		
L1834	RB		KO, WITHOUT KNEE JOINT, RIGID, MOLDED TO PATIENT MODEL	CMN	IOC	
L1834	NU		KO, WITHOUT KNEE JOINT, RIGID, MOLDED TO PATIENT MODEL	CMN		
L1836	NU		KO RIGID W/O JOINTS PRE OTS	CMN		
L1840	RB		KO, DEROTATION, MEDIAL-LATERAL, ANTERIOR CRUCIATE LIGAMENT, CUSTOM FABRICATED TO PATIENT MODEL	CMN	IOC	
L1840	NU		KO, DEROTATION, MEDIAL-LATERAL, ANTERIOR CRUCIATE LIGAMENT, CUSTOM FABRICATED TO PATIENT MODEL	CMN		
L1843	NU		KO SINGLE UPRIGHT PRE CST	PA		
L1845	RB		KO DOUBLE UPRIGHT PRE CST	CMN	IOC	
L1845	NU		KO DOUBLE UPRIGHT PRE CST	CMN		
L1846	RB		KO W ADJ FLEX/EXT ROTAT MOLD	CMN	IOC	
L1846	NU		KO W ADJ FLEX/EXT ROTAT MOLD	CMN		
L1847	NU		KO DBL UPRIGHT W/AIR PRE CST	CMN		
L1848	NU		KO DBL UPRIGHT W/AIR PRE OTS	CMN		
L1850	RB		KO SWEDISH TYPE PRE OTS	CMN	IOC	
L1850	NU		KO SWEDISH TYPE PRE OTS	CMN		
L1851	NU		KO SINGLE UPRIGHT PREFAB OTS	CMN		
L1852	NU		KO DOUBLE UPRIGHT PREFAB OTS	CMN		
L1860	RB		KO, MODIFICATION OF SUPRACONDYLAR PROSTHETIC SOCKET, MOLDED TO PATIENT MODEL (SK)	CMN	IOC	

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L1860	NU		KO, MODIFICATION OF SUPRACONDYLAR PROSTHETIC SOCKET, MOLDED TO PATIENT MODEL (SK)	CMN		
L1885	RB		KO, SINGLE OR DOUBLE UPRIGHT, THIGH AND CALF, WITH FUNTIONAL ACTIVE RESISTANCE CONTROL	CMN	IOC	
L1900	RB		ANKLE-FOOT ORTHOSIS (AFO), SPRING WIRE, DORSIFLEXION ASSIST CALF BAND	CMN	IOC	
L1900	NU		ANKLE-FOOT ORTHOSIS (AFO), SPRING WIRE, DORSIFLEXION ASSIST CALF BAND	CMN		
L1902	RB		AFO ANKLE GAUNTLET PRE OTS	CMN	IOC	
L1902	NU		AFO ANKLE GAUNTLET PRE OTS	CMN		
L1904	RB		AFO MOLDED ANKLE GAUNTLET	CMN	IOC	
L1904	NU		AFO MOLDED ANKLE GAUNTLET	CMN		
L1906	RB		AFO MULTILIG ANK SUP PRE OTS	CMN	IOC	
L1906	NU		AFO MULTILIG ANK SUP PRE OTS	CMN		
L1907	NU		AFO SUPRAMALLEOLAR CUSTOM	CMN		
L1910	RB		AFO, POSTERIOR, SINGLE BAR, CLASP ATTACHMENT TO SHOE COUNTER	CMN	IOC	
L1910	NU		AFO, POSTERIOR, SINGLE BAR, CLASP ATTACHMENT TO SHOE COUNTER	CMN		
L1920	RB		AFO, SINGLE UPRIGHT WITH STATIC OR ADJUSTABLE STOP (PHELPS OR PERLSTEIN TYPE)	CMN	IOC	
L1920	NU		AFO, SINGLE UPRIGHT WITH STATIC OR ADJUSTABLE STOP (PHELPS OR PERLSTEIN TYPE) CUSTOM FABRICATED	CMN		
L1930	RB		AFO, PLASTIC	CMN	IOC	
L1930	NU		AFO, PLASTIC	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L1932	NU		AFO,RIGID ANTERIOR TIBIAL SECTION, TOTAL CARBON FIBER OR EQUAL	CMN		
L1940	RB		AFO, MOLDED TO PATIENT MODEL, PLASTIC	CMN	IOC	
L1940	NU		AFO, MOLDED TO PATIENT MODEL, PLASTIC	CMN		
L1945	RB		AFO, MOLDED TO PATIENT MODEL, PLASTIC, RIGID ANTERIOR TIBIAL SECTION (FLOOR REACTION)	CMN	IOC	
L1945	NU		AFO, MOLDED TO PATIENT MODEL, PLASTIC, RIGID ANTERIOR TIBIAL SECTION (FLOOR REACTION)	CMN		
L1950	RB		AFO, SPIRAL, MOLDED TO PATIENT MODEL (IRM TYPE), PLASTIC	CMN	IOC	
L1950	NU		AFO, SPIRAL, MOLDED TO PATIENT MODEL (IRM TYPE), PLASTIC	CMN		
L1951	NU		AFO SPIRAL PREFABRICATED	CMN		
L1960	RB		AFO, POSTERIOR SOLID ANKLE, MOLDED TO PATIENT MODEL, PLASTIC	CMN	IOC	
L1960	NU		AFO, POSTERIOR SOLID ANKLE, MOLDED TO PATIENT MODEL, PLASTIC	CMN		
L1970	RB		AFO, PLASTIC MOLDED TO PATIENT MODEL, WITH ANKLE JOINT	CMN	IOC	
L1970	NU		AFO, PLASTIC MOLDED TO PATIENT MODEL, WITH ANKLE JOINT	CMN		
L1971	NU		AFO W/ANKLE JOINT, PREFAB	CMN		
L1980	RB		AFO, SINGLE UPRIGHT FREE PLANTAR DORSIFLEXION, SOLID STIRRUP, CALF BAND/CUFF (SINGLE BAR BK ORTHOS	CMN	IOC	
L1980	NU		AFO, SINGLE UPRIGHT FREE PLANTAR DORSIFLEXION, SOLID STIRRUP, CALF BAND/CUFF (SINGLE BAR BK ORTHOS	CMN		
L1990	RB		AFO, DOUBLE UPRIGHT FREE PLANTAR DORSIFLEXION, SOLID STIRRUP, CALF BAND/CUFF (DOUBLE BAR BK ORTHOS	CMN	IOC	

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L1990	NU		AFO, DOUBLE UPRIGHT FREE PLANTAR DORSIFLEXION, SOLID STIRRUP, CALF BAND/CUFF (DOUBLE BAR BK ORTHOS	CMN		
L2000	RB		KNEE-ANKLE-FOOT-ORTHOSES (KAFO), SINGLE UPRIGHT, FREE KNEE, FREE ANKLE, SOLID STIRRUP, THIGH AND CAL	CMN	IOC	
L2000	NU		KAFO,SINGLE UPRIGHT, FREE KNEE ANKLE, SOLID STIRUP, THIGH AND CALF BANDS/CUFF SINGLE BAR AK ORTHOSIS	CMN		
L2005	NU		KAFO SNG/DBL MECHANICAL ACT	CMN		
L2006	NU		KAF SNG/DBL SWG/STN MCPR CUS	PA	IOC	
L2006	RB		KAF SNG/DBL SWG/STN MCPR CUS	PA	IOC	
L2010	RB		KAFO, SINGLE UPRIGHT, FREE ANKLE, SOLID STIRRUP, THIGH AND CALF BANDS/CUFFS (SINGLE BAR AK ORTHOSIS)	CMN	IOC	
L2010	NU		KAFO, SNGL UPRIGHT,FREE ANKLE,SOLID STIRUP, THIGH AND CALF BANDS/CUFFS (SINGLE BAR AK ORTHOSIS)	CMN		
L2020	RB		KAFO, DOUBLE UPRIGHT, FREE KNEE, FREE ANKLE, SOLID STIRRUP, THIGH AND CALF BANDS/CUFFS (DOUBLE BAR)	CMN	IOC	
L2020	NU		KAFO, DOUBLE UPRIGHT, FREE ANKLE,SOLID STIRRUP,THIGH AND CALF BANDS/CUFFS(DOUBLE BAR AK ORTHOSIS)	CMN		
L2030	RB		KAFO, DOUBLE UPRIGHT, FREE ANKLE, SOLID STIRRUP, THIGH AND CALF BANDS/CUFFS, (DOUBLE BAR AK ORTHOS	CMN	IOC	
L2030	NU		KAFO, DOUBLE UPRIGHT, FREE ANKLE, SOLID STIRRUP, THIGH AND CALF BANDS/CUFFS, (DOUBLE BAR AK ORTHOS	CMN		
L2034	RB		KAFO PLA SIN UP W/WO K/A CUS	CMN	IOC	
L2034	NU		KAFO PLA SIN UP W/WO K/A CUS	CMN		
L2035	NU		KAFO,FULL PLASTIC, STATIC (PED SZ) W/O FREE	PA		
L2036	RB		KAFO PLAS DOUB FREE KNEE MOL	CMN	IOC	

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L2036	NU		KAFO PLAS DOUB FREE KNEE MOL	CMN		
L2037	RB		KAFO PLAS SING FREE KNEE MOL	CMN	IOC	
L2037	NU		KAFO PLAS SING FREE KNEE MOL	CMN		
L2038	RB		KAFO, FULL PLASTIC, W/O KNEE JOINT, MULTI-AXIS ANKLE	CMN	IOC	
L2038	NU		KAFO, FULL PLASTIC, W/O KNEE JOINT, MULTI-AXIS ANKLE	CMN		
L2040	RB		HIP-KNEE-ANKLE-FOOT ORTHOSIS (HKAFO) TORSION CONTROL, BILATERAL ROTATION STRAPS, PELVIC BAND/BELT	CMN	IOC	
L2040	NU		HIP-KNEE-ANKLE-FOOT ORTHOSIS (HKAFO) TORSION CONTROL, BILATERAL ROTATION STRAPS, PELVIC BAND/BELT	CMN		
L2050	RB		HKAFO, TORSION CONTROL, BILATERAL TORSION CABLES, HIP JOINT, PELVIC BAND/BELT	CMN	IOC	
L2050	NU		HKAFO, TORSION CONTROL, BILATERAL TORSION CABLES, HIP JOINT, PELVIC BAND/BELT	CMN		
L2060	RB		HKAFO, TORSION CONTROL, BILATERAL TORSION CABLES, BALL BEARING HIP JOINT, PELVIC BAND/ BELT	CMN	IOC	
L2060	NU		HKAFO, TORSION CONTROL, BILATERAL TORSION CABLES, BALL BEARING HIP JOINT, PELVIC BAND/ BELT	CMN		
L2070	RB		HKAFO, TORSION CONTROL, UNILATERAL ROTATION STRAPS, PELVIC BAND/BELT	CMN	IOC	
L2070	NU		HKAFO, TORSION CONTROL, UNILATERAL ROTATION STRAPS, PELVIC BAND/BELT	CMN		
L2080	RB		HKAFO, TORSION CONTROL, UNILATERAL TORSION CABLE, HIP JOINT, PELVIC BAND/BELT	CMN	IOC	
L2080	NU		HKAFO, TORSION CONTROL, UNILATERAL TORSION CABLE, HIP JOINT, PELVIC BAND/BELT	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L2090	RB		HKAFO, TORSION CONTROL, UNILATERAL TORSION CABLE, BALL BEARING HIP JOINT, PELVIC BAND/ BELT	CMN	IOC	
L2090	NU		HKAFO, TORSION CONTROL, UNILATERAL TORSION CABLE, BALL BEARING HIP JOINT, PELVIC BAND/ BELT	CMN		
L2106	RB		AFO, FRACTURE ORTHOSIS, TIBIAL FRACTURE CAST ORTHOSIS, THERMOPLASTIC TYPE CASTING MATERIAL, MOLDED T	CMN	IOC	
L2106	NU		AFO, FRACTURE ORTHOSIS, TIBIAL FRACTURE CAST ORTHOSIS, THERMOPLASTIC TYPE CASTING MATERIAL, MOLDED T	CMN		
L2108	RB		AFO, FRACTURE ORTHOSIS, TIBIAL FRACTURE CAST ORTHOSIS, MOLDED TO PATIENT MODEL	CMN	IOC	
L2108	NU		AFO, FRACTURE ORTHOSIS, TIBIAL FRACTURE CAST ORTHOSIS, MOLDED TO PATIENT MODEL	CMN		
L2112	RB		AFO, FRACTURE ORTHOSIS, TIBIAL FRACTURE ORTHOSIS, SOFT	CMN	IOC	
L2112	NU		AFO, FRACTURE ORTHOSIS, TIBIAL FRACTURE CAST ORTHOSIS,SOFT, PRE-FABRICATED,INCLUDES FITTING & ADJUST	CMN		
L2114	RB		AFO, FRACTURE ORTHOSIS, TIBIAL FRACTURE ORTHOSIS, SEMI-RIGID	CMN	IOC	
L2114	NU		AFO, FRACTURE ORTHOSIS, TIBIAL FRACTURE ORTHOSIS, SEMI-RIGID	CMN		
L2116	RB		AFO, FRACTURE ORTHOSIS, TIBIAL FRACTURE ORTHOSIS, RIGID	CMN	IOC	
L2116	NU		AFO, FRACTURE ORTHOSIS, TIBIAL FRACTURE ORTHOSIS, RIGID	CMN		
L2126	RB		KAFO, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, THERMOPLASTIC TYPE CASTING MATERIAL, MOLDED	CMN	IOC	
L2126	NU		KAFO, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, THERMOPLASTIC TYPE CASTING MATERIAL, MOLDED	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L2128	RB		KAFO, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, MOLDED TO PATIENT MODEL	CMN	IOC	
L2128	NU		KAFO, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, MOLDED TO PATIENT MODEL	CMN		
L2132	RB		KAFO, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, SOFT	CMN	IOC	
L2132	NU		KAFO, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, SOFT	CMN		
L2134	RB		KAFO, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, SEMI-RIGID	CMN	IOC	
L2134	NU		KAFO, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, SEMI-RIGID	CMN		
L2136	RB		KAFO, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, RIGID	CMN	IOC	
L2136	NU		KAFO, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, RIGID	CMN		
L2180	NU		ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, PLASTIC SHOE INSERT WITH ANKLE JOINTS	CMN		
L2182	NU		ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, DROP LOCK KNEE JOINT	CMN		
L2184	NU		ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, LIMITED MOTION KNEE JOINT	CMN		
L2186	NU		ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, ADJUSTABLE MOTION KNEE JOINT, LERMAN TYPE	CMN		
L2188	NU		ADDITION TO LOWER EXTREMITY FRACTURE OTHOSIS, QUADRILATERAL BRIM	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L2190	NU		ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, WAIST BELT	CMN		
L2192	NU		ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, HIP JOINT, PELVIC BAND, THIGH FLANGE, AND PELVIC BELT	CMN		
L2200	NU		ADDITION TO LOWER EXTREMITY, LIMITED ANKLE MOTION, EACH JOINT	CMN		
L2210	NU		ADDITION TO LOWER EXTREMITY, DORSIFLEXION ASSIST (PLANTAR FLEXION RESIST), EACH JOINT	CMN		
L2220	NU		ADDITION TO LOWER EXTREMITY, DORSIFLEXION AND PLANTAR FLEXION ASSIST/RESIST, EACH JOINT	CMN		
L2230	NU		ADDITION TO LOWER EXTREMITY, SPLIT FLAT CALIPER STIRRUPS AND PLATE ATTACHMENT	CMN		
L2232	NU		ADDITION TO LOWER EXTREMITY ORTHOSIS, ROCKER BOTTOM FOR TOTAL CONTACT ANKLE	CMN		
L2240	NU		ADDITION TO LOWER EXTREMITY, ROUND CALIPER AND PLATE ATTACHMENT	CMN		
L2250	NU		ADD TO LOWER EXTREMITY, FOOT PLATE MOLDED, STIRUP ATTACHMENT	CMN		
L2260	NU		ADD TO LOWER EXTREMITY, REINFORCED SOLID STIRUP SCOTT-CRAIG TYPE	CMN		
L2265	NU		ADDITION TO LOWER EXTREMITY, LONG TONGUE STIRRUP	CMN		
L2270	NU		ADD LOWER EXTREMITY VARUS/VULGUS CORRECTION T STRAP, PADDED/LINED OR MALLEOLUS PAD	CMN		
L2275	NU		ADDITION TO LOWER EXTREMITY, VARUS/VULGUS CORRECTION, PLASTIC MODIFICATION, PADDED/LINED	CMN		
L2280	NU		ADDITION TO LOWER EXTREMITY, MOLDED INNER BOOT	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L2300	NU		ADD, ABDUCTION BAR BILATERAL HIP INVOLVEMENT, JOINTED, ADJUSTABLE	CMN		
L2310	NU		ADDITION, ABDUCTION BAR STRAIGHT	CMN		
L2320	NU		NON MOLDED LACER, FOR CUSTOM FABRICATED ORTHOSIS, LOWER EXTREMITY	CMN		
L2330	NU		LACER MOLDED TO PATIENT MODEL, FOR CUSTOM LOWER EXT	CMN		
L2335	NU		ADDITION, ANTERIOR SWING BAND	CMN		
L2340	NU		ADDITION PRE TIBIAL SHELL MOLDED TO PATIENT	CMN		
L2350	NU		ADDITION PROSTHETIC TYPE BK SOCKET, MOLDED TO PATIENT (USED FOR PTB AFO)	CMN		
L2360	NU		ADDITION, EXTENDED STEEL SHANK	CMN		
L2370	NU		ADDITION TO LOWER EXTREMITY, PATTEN BOTTOM	CMN		
L2375	NU		ADDITION TO LOWER EXTREMITY, TORSION CONTROL,ANKLEJOINT & HALF SOLID STIRRUP	CMN		
L2380	NU		ADDITION TO LOWER EXTREMITY, TORSION CONTROL,STRAIGHT KNEE JOINT, EACH JOINT	CMN		
L2385	NU		ADDITION, STRAIGHT KNEE JOINT, HEAVY DUTY EACH JOINT	CMN		
L2387	RB		ADD LE POLY KNEE CUSTOM KAFO	CMN	IOC	
L2387	NU		ADD LE POLY KNEE CUSTOM KAFO	CMN		
L2390	RB		ADDITION	CMN	IOC	
L2390	NU		ADDITION, OFFSET KNEE JOINT, EACH JOINT	CMN		
L2395	NU		ADDITION, OFFSET KNEE JOINT, HEAVY DUTY EACH JOINT	CMN		
L2397	NU		ADDITION TO LOWER EXTREMITY ORTHOSIS, SUSPENSION SLEEVE	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L2405	NU		KNEE JOINT DROP LOCK EA JNT	CMN		
L2415	NU		ADDITION TO KNEE LOCK WITH INTEGRATED RELEASE MECHANISM (BAIL,CABLE, OR EQUAL) ANY MATERIAL, EACH JOINT	CMN		
L2425	NU		ADDITION TO KNEE JOINT, DISC OR DIAL LOCK FOR ADJUSTABLE KNEE FLEXION, EACH JOINT	CMN		
L2430	NU		ADDITION TO KNEE JOINT, RATCHET LOCK FOR ACTIVE AND PROGRESSIVE KNEE EXTENSION, EACH JOINT	CMN		
L2492	NU		ADDITION TO KNEE JOINT, LIFT LOOP FOR DROP LOCK RING	CMN		
L2500	NU		ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, GLUTEAL/ISCHIAL WEIGHT BEARING, RING	CMN		
L2510	NU		ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, QUADRI- LATERAL BRIM, MOLDED TO PATIENT MODEL	CMN		
L2520	NU		ADDITION QUADRILATERAL BRIM, CUSTOM FITTED	CMN		
L2525	NU		ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, ISCHIAL CONTAINMENT/NARROW M-L BRIM MOLDED TO PAT	CMN		
L2526	NU		ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, ISCHIAL CONTAINMENT/NARROW M-L BRIM, CUSTOM FITTED	CMN		
L2530	NU		ADDITION, THIGH WEIGHT BEARING, LACER NON MOLDED	CMN		
L2540	NU		ADDITION THIGH WEIGHT BEARING LACER MOLDED TO PATIENT	CMN		
L2550	NU		ADDITION THIGH WEIGHT BEARING HIGH ROLL CUFF	CMN		
L2570	NU		ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, HIP JOINT, CLEVIS TYPE TWO POSITION JOINT, EACH	CMN		
L2580	NU		ADDITION TO LOWER EXTREMITY,PELVIC CONTROL, PELVIC SLING	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L2600	NU		ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, HIP JOINT, CLEVIS TYPE, OR THRUST BEARING, FREE, EACH	CMN		
L2610	NU		ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, HIP JOINT, CLEVIS OR THRUST BEARING, LOCK, EACH	CMN		
L2620	NU		ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, HIP JOINT, HEAVY DUTY, EACH	CMN		
L2622	NU		ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, HIP JOINT, ADJUSTABLE FLEXION, EACH	CMN		
L2624	NU		ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, HIP JOINT, ADJUSTABLE FLEXION, EXTENSION, ABDUCTION CON	CMN		
L2627	NU		ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, PLASTIC, MOLDED TO PATIENT MODEL, RECIPROCATING HIP JOI	CMN		
L2628	NU		ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, METAL FRAME, RECIPROCATING HIP JOINT AND CABLES	CMN		
L2630	NU		ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, BAND AND BELT, UNILATERAL	CMN		
L2640	NU		ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, BAND AND BELT, BILATERAL	CMN		
L2650	NU		ADDITION TO LOWER EXTREMITY, PELVIC AND THORACIC CONTROL, GLUTEAL PAD, EACH	CMN		
L2660	NU		ADDITION TO LOWER EXTREMITY, THORACIC CONTROL, THORACIC BAND	CMN		
L2670	NU		ADDITION TO LOWER EXTREMITY, THORACIC CONTROL, PARASPINAL UPRIGHTS	CMN		
L2680	NU		ADDITION TO LOWER EXTREMITY, THORACIC CONTROL, LATERAL SUPPORT UPRIGHTS	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L2750	NU		ADDITION TO LOWER EXTREMITY ORTHOSIS, PLATING CHROME OR NICKEL, PER BAR	CMN		
L2755	NU		HIGH STRENGTH LIGHTWEIGHT LOWER EXTREMITY ORTHOSIS	CMN		
L2760	NU		ADDITION TO LOWER EXTREMITY ORTHOSIS, EXTENSION, PER EXTENSION, PER BAR (FOR LINEAL ADJUSTMENT)	CMN		
L2780	NU		ADDITION TO LOWER EXTREMITY ORTHOSIS, NON-CORROSIVE FINISH, PER BAR	CMN		
L2785	NU		ADDITION TO LOWER EXTREMITY ORTHOSIS, DROP LOCK RETAINER, EACH	CMN		
L2795	NU		ADDITION TO LOWER EXTREMITY ORTHOSIS, KNEE CONTROL, FULL KNEECAP	CMN		
L2800	NU		KNEE CONTROL KNEE CAP, MEDIAL OR LATERAL LOWER EXTREMITY ORTHOSIS	CMN		
L2810	NU		ADDITION TO LOWER EXTREMITY ORTHOSIS, KNEE CONTROL, CONDYLAR PAD	CMN		
L2820	NU		ADDITION TO LOWER EXTREMITY ORTHOSIS, SOFT INTERFACE FOR MOLDED PLASTIC, BELOW KNEE SECTION	CMN		
L2830	NU		ADDITION TO LOWER EXTREMITY ORTHOSIS, SOFT INTERFACE FOR MOLDED PLASTIC, ABOVE KNEE SECTION	CMN		
L2840	NU		ADDITION TO LOWER EXTREMITY ORTHOSIS, TIBIAL LENGTH SOCK, FRACTURE OR EQUAL, EACH	CMN		
L2850	NU		ADDITION TO LOWER EXTREMITY ORTHOSIS, FEMORAL LENGTH SOCK, FRACTURE OR EQUAL, EACH	CMN		
L2861	NU		TORSION MECHANISM KNEE/ANKLE	CMN	IOC	
L2999	NU		LOWER EXTREMITY ORTHOSES, NOT OTHERWISE SPECIFIED	PA	IOC	

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L3000	NU		FOOT, INSERT, REMOVABLE, MOLDED TO PATIENT MODEL, UCB TYPE, BERKELEY SHELL, EACH	CMN		
L3001	NU		FOOT, INSERT, REMOVABLE, MOLDED TO PATIENT MODEL, SPENCO, EACH	CMN		
L3002	NU		FOOT, INSERT, REMOVABLE, MOLDED TO PATIENT MODEL, PLASTAZOTE OR EQUAL, EACH	CMN		
L3003	NU		FOOT, INSERT, REMOVABLE, MOLDED TO PATIENT MODEL, SILICONE GEL, EACH	CMN		
L3010	NU		FOOT, INSERT, REMOVABLE, MOLDED TO PATIENT MODEL, LONGITUDINAL ARCH SUPPORT, EACH	CMN		
L3020	NU		FOOT, INSERT, REMOVABLE, MOLDED TO PATIENT MODEL, LONGITUDINAL/ METATARSAL SUPPORT, EACH	CMN		
L3030	NU		FOOT, INSERT, REMOVABLE, FORMED TO PATIENT FOOT, EACH	CMN		
L3031	NU		FOOT LAMIN/PREPREG COMPOSITE	CMN		
L3040	NU		FOOT, ARCH SUPPORT, REMOVABLE, PREMOLDED, LONGITUDINAL, EACH	CMN		
L3050	NU		FOOT, ARCH SUPPORT, REMOVABLE, PREMOLDED, METATARSAL, EACH	CMN		
L3060	NU		FOOT, ARCH SUPPORT, REMOVABLE, PREMOLDED, LONGITUDINAL/ METATARSAL, EACH	CMN		
L3070	NU		FOOT, ARCH SUPPORT, NON-REMOVABLE ATTACHED TO SHOE, LONGITUDINAL, EACH	CMN		
L3080	NU		FOOT, ARCH SUPPORT, NON-REMOVABLE ATTACHED TO SHOE, METATARSAL, EACH	CMN		
L3090	NU		FOOT, ARCH SUPPORT, NON-REMOVABLE ATTACHED TO SHOE, LONGITUDINAL/METATARSAL, EACH	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L3100	NU		HALLUS-VALGUS NT DYN PRE OTS	CMN		
L3140	NU		FOOT, ABDUCTION ROTATION BAR, INCLUDING SHOES	CMN		
L3150	NU		FOOT, ABDUCTION ROTATION BAR, WITHOUT SHOES	CMN		
L3160	NU		FOOT, ADJUSTABLE SHOE-STYLED POSITIONING DEVICE	CMN		
L3170	NU		FOOT PLAS HEEL STABI PRE OTS	CMN		
L3201	NU		ORTHOPEDIC SHOE, OXFORD WITH SUPINATOR OR PRONATOR, INFANT, EACH	CMN		
L3202	NU		ORTHOPEDIC SHOE, OXFORD WITH SUPINATOR OR PRONATOR, CHILD, EACH	CMN		
L3203	NU		ORTHOPEDIC SHOE, OXFORD WITH SUPINATOR OR PRONATOR, JUNIOR, EACH	CMN		
L3204	NU		ORTHOPEDIC SHOE, HIGHTOP WITH SUPINATOR OR PRONATOR, INFANT, EACH	CMN		
L3206	NU		ORTHOPEDIC SHOE, HIGHTOP WITH SUPINATOR OR PRONATOR, CHILD, EACH	CMN		
L3207	NU		ORTHOPEDIC SHOE, HIGHTOP WITH SUPINATOR OR PRONATOR, JUNIOR, EACH	CMN		
L3208	NU		SURGICAL BOOT, EACH, INFANT	CMN		
L3209	NU		SURGICAL BOOT, EACH, CHILD	CMN		
L3211	NU		SURGICAL BOOT, EACH, JUNIOR	CMN		
L3212	NU		BENESCH BOOT, PAIR, INFANT	CMN		
L3213	NU		BENESCH BOOT, PAIR, CHILD	CMN		
L3214	NU		BENESCH BOOT, PAIR, JUNIOR	CMN		
L3215	NU		ORTHOPEDIC FTWEAR LADIES OXF	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L3216	NU		ORTHOPED LADIES SHOES DPTH I	CMN		
L3217	NU		ORTHOPEDIC FOOTWEAR, LADIES SHOE, HIGHTOP, DEPTH INLAY, EACH	CMN		
L3219	NU		ORTHOPEDIC MENS SHOES OXFORD	CMN		
L3221	NU		ORTHOPEDIC MENS SHOES DPTH I	CMN		
L3222	NU		MENS SHOES HIGHTOP DEPTH INL	CMN		
L3224	NU		ORTHOPEDIC FOOTWEAR, WOMAN'S SHOE, OXFORD, USED ASAN INTEGRAL PART OF A BRACE (ORTHOSIS)	CMN		
L3225	NU		ORTHOPEDIC FOOTWEAR, MAN'S SHOE, OXFORD, USED AS AN INTEGRAL PART OF A BRACE (ORTHOSIS)	CMN		
L3230	NU		CUSTOM SHOES DEPTH INLAY	CMN		
L3250	NU		ORTHOPEDIC FOOTWEAR, CUSTOM MOLDED SHOE, REMOVABLE INNER MOLD, PROSTHETIC SHOE, EACH	PA	IOC	
L3251	NU		FOOT, SHOE MOLDED TO PATIENT MODEL, SILICONE SHOE, EACH	PA	IOC	
L3252	NU		FOOT, SHOE MOLDED TO PATIENT MODEL, PLASTAZOTE (OR SIMILAR), CUSTOM FABRICATED, EACH	PA	IOC	
L3253	NU		FOOT, MOLDED SHOE PLASTAZOTE (OR SIMILAR) CUSTOM FITTED, EACH	CMN	IOC	
L3254	NU		NON-STANDARD SIZE OR WIDTH	PA	IOC	
L3255	NU		NON-STANDARD SIZE OR LENGTH	PA	IOC	
L3260	NU		AMBULATORY SURGICAL BOOT EAC	CMN		
L3300	NU		LIFT, ELEVATION, HEEL, TAPERED TO METATARSALS, PER INCH	CMN		
L3310	NU		LIFT, ELEVATION, HEEL AND SOLE, NEOPRENE, PER INCH	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L3320	NU		LIFT, ELEVATION, HEEL AND SOLE, CORK, PER INCH	CMN		
L3330	NU		LIFT, ELEVATION, METAL EXTENSION (SKATE)	CMN		
L3332	NU		LIFT, ELEVATION, INSIDE SHOE, TAPERED, UP TO ONE-HALF INCH	CMN		
L3334	NU		LIFT, ELEVATION, HEEL, PER INCH	CMN		
L3340	NU		HEEL WEDGE, SACH	CMN		
L3350	NU		HEEL WEDGE	CMN		
L3360	NU		SOLE WEDGE, OUTSIDE SOLE	CMN		
L3370	NU		SOLE WEDGE, BETWEEN SOLE	CMN		
L3380	NU		CLUBFOOT WEDGE	CMN		
L3390	NU		OUTFLARE WEDGE	CMN		
L3400	NU		METATARSAL BAR WEDGE, ROCKER	CMN		
L3410	NU		METATARSAL BAR WEDGE, BETWEEN SOLE	CMN		
L3420	NU		FULL SOLE AND HEEL WEDGE, BETWEEN SOLE	CMN		
L3430	NU		HEEL, COUNTER, PLASTIC REINFORCED	CMN		
L3440	NU		HEEL, COUNTER, LEATHER REINFORCED	CMN		
L3450	NU		HEEL, SACH CUSHION TYPE	CMN		
L3455	NU		HEEL, NEW LEATHER, STANDARD	CMN		
L3460	NU		HEEL, NEW RUBBER, STANDARD	CMN		
L3465	NU		HEEL, THOMAS WITH WEDGE	CMN		
L3470	NU		HEEL, THOMAS EXTENDED TO BALL	CMN		
L3480	NU		HEEL, PAD AND DEPRESSION FOR SPUR	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L3485	NU		HEEL, PAD, REMOVABLE FOR SPUR	CMN		
L3500	NU		ORTHOPEDIC SHOE ADDITION; INSOLE, LEATHER	CMN		
L3510	NU		INSOLE, RUBBER	CMN		
L3520	NU		INSOLE, FELT COVERED WITH LEATHER	CMN		
L3530	NU		SOLE, HALF	CMN		
L3540	NU		SOLE, FULL	CMN		
L3550	NU		TOE TAP, STANDARD	CMN		
L3560	NU		TOE TAP, HORSESHOE	CMN		
L3570	NU		SPECIAL EXTENSION TO INSTEP (LEATHER WITH EYELETS)	CMN		
L3580	NU		CONVERT INSTEP TO VELCRO CLOSURE	CMN		
L3590	NU		CONVERT FIRM SHOE COUNTER TO SOFT COUNTER	CMN		
L3595	NU		MARCH BAR	CMN		
L3600	NU		TRANSFER OF ORTHOSIS FROM ONE SHOE TO ANOTHER, CALIPER PLATE EXISTING	CMN		
L3610	NU		TRANSFER CALIPER PLATE, NEW	CMN		
L3620	NU		TRANSFER SOLID STIRRUP, EXISTING	CMN		
L3630	NU		TRANSFER SOLID STIRRUP, NEW	CMN		
L3640	NU		TRANSFER, DENNIS BROWNE SPLINT (RIVETON) BOTH SHOES	CMN		
L3649	NU		ORTHOPEDIC SHOE, MODIFICATION, ADDITION OR TRANSFER, NOT OTHERWISE SPECIFIED	PA	IOC	
L3650	RB		SO 8 ABD RESTRAINT PRE OTS	CMN	IOC	
L3650	NU		SO 8 ABD RESTRAINT PRE OTS	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L3660	RB		SO 8 AB RSTR CAN/WEB PRE OTS	CMN	IOC	
L3660	NU		SO 8 AB RSTR CAN/WEB PRE OTS	CMN		
L3670	RB		SO ACRO/CLAV CAN WEB PRE OTS	CMN	IOC	
L3670	NU		SO ACRO/CLAV CAN WEB PRE OTS	CMN		
L3671	RB		SO CAP DESIGN W/O JNTS CF	CMN	IOC	
L3671	NU		SO CAP DESIGN W/O JNTS CF	CMN		
L3674	NU		SO AIRPLANE W/WO JOINT CF	CMN		
L3675	NU		SO VEST CANVAS/WEB PRE OTS	CMN		
L3702	RB		EO W/O JOINTS CF	CMN	IOC	
L3702	NU		EO W/O JOINTS CF	CMN		
L3710	RB		EO ELAS W/METAL JNTS PRE OTS	CMN	IOC	
L3710	NU		EO ELAS W/METAL JNTS PRE OTS	CMN		
L3720	RB		EO, DOUBLE UPRIGHT WITH FOREARM/ARM CUFFS, FREE MOTION	CMN	IOC	
L3720	NU		EO, DOUBLE UPRIGHT WITH FOREARM/ARM CUFFS, FREE MOTION	CMN		
L3730	RB		EO, DOUBLE UPRIGHT WITH FOREARM/ARM CUFFS, EXTENSION/ FLEXION ASSIST	CMN	IOC	
L3730	NU		EO, DOUBLE UPRIGHT WITH FOREARM/ARM CUFFS, EXTENSION/ FLEXION ASSIST	CMN		
L3740	RB		EO, DOUBLE UPRIGHT WITH FOREARM/ARM CUFFS, ADJUSTABLE POSITION LOCK WITH ACTIVE CONTROL	CMN	IOC	
L3740	NU		EO, DOUBLE UPRIGHT WITH FOREARM/ARM CUFFS, ADJUSTABLE POSITION LOCK WITH ACTIVE CONTROL,CUSTOM FABRI	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L3760	NU		WITH ADJUSTABLE POSITION LOCKING JOINT(S),PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	CMN		
L3761	NU		EO, ADJ LOCK JOINT PREFAB QT	CMN		
L3761	RB		EO, ADJ LOCK JOINT PREFAB QT	CMN		
L3762	NU		EO RIGID W/O JOINTS PRE OTS	CMN		
L3763	RB		EWHO RIGID W/O JNTS CF	CMN	IOC	
L3763	NU		EWHO RIGID W/O JNTS CF	CMN		
L3764	RB		EWHO W/JOINT(S) CF	CMN	IOC	
L3764	NU		EWHO W/JOINT(S) CF	CMN		
L3765	RB		EWHFO RIGID W/O JNTS CF	CMN	IOC	
L3765	NU		EWHFO RIGID W/O JNTS CF	CMN		
L3766	RB		EWHFO W/JOINT(S) CF	CMN	IOC	
L3766	NU		EWHFO W/JOINT(S) CF	CMN		
L3806	RB		WHFO W/JOINT(S) CUSTOM FAB	CMN	IOC	
L3806	NU		WHFO W/JOINT(S) CUSTOM FAB	CMN	IOC	
L3808	NU		WHFO, RIGID W/O JOINTS	CMN	IOC	
L3891	NU		TORSION MECHANISM WRIST/ELBO	CMN	IOC	
L3900	NU		WHFO, DYNAMIC FLEXOR HINGE, RECIP. WRIST EXTEN/FLEX, FINGER FLEXION/EXTEN, WRIST OR FINGER DRIVE	CMN		
L3901	NU		WHFO, DYNAMIC FLEXOR HINGE, RECIP. WRIST EXTEN./FLEX., FINGER FLEX./EXTEN., CABLE DRIVEN,CUSTOM FABR	CMN		
L3905	RB		WHO W/NONTORSION JNT(S) CF	CMN	IOC	

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L3905	NU		WHO W/NONTORSION JNT(S) CF	CMN		
L3906	RB		WRIST HAND ORTHOSIS, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES	CMN	IOC	
L3906	NU		WRIST HAND ORTHOSIS, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES	CMN		
L3908	RB		WHO COCK-UP NONMOLDE PRE OTS	CMN	IOC	
L3908	NU		WHO COCK-UP NONMOLDE PRE OTS	CMN		
L3912	RB		HFO FLEXION GLOVE PRE OTS	CMN	IOC	
L3912	NU		HFO FLEXION GLOVE PRE OTS	CMN		
L3913	RB		HFO W/O JOINTS CF	CMN	IOC	
L3913	NU		HFO W/O JOINTS CF	CMN		
L3915	RB		WHO NONTORSION JNTS PRE CST	CMN	IOC	
L3915	NU		WHO NONTORSION JNTS PRE CST	CMN		
L3916	NU		WHO NONTORSION JNTS PRE OTS	CMN		
L3917	NU		METACARP FX ORTHOSIS PRE CST	CMN		
L3918	NU		METACARP FX ORTHOSIS PRE OTS	CMN		
L3919	RB		HO W/O JOINTS CF	CMN	IOC	
L3919	NU		HO W/O JOINTS CF	CMN		
L3921	RB		HFO W/JOINT(S) CF	CMN	IOC	
L3921	NU		HFO W/JOINT(S) CF	CMN		
L3923	NU		HFO WITHOUT JOINTS PRE CST	CMN		
L3924	NU		HFO WITHOUT JOINTS PRE OTS	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L3925	RB		FO PIP DIP JNT/SPRNG PRE OTS	CMN	IOC	
L3925	NU		FO PIP DIP JNT/SPRNG PRE OTS	CMN		
L3927	RB		FO PIP DIP NO JT SPR PRE OTS	CMN	IOC	
L3927	NU		FO PIP DIP NO JT SPR PRE OTS	CMN		
L3929	RB		HFO NONTORSION JNTS PRE CST	CMN	IOC	
L3929	NU		HFO NONTORSION JNTS PRE CST	CMN		
L3930	NU		HFO NONTORSION JNTS PRE OTS	CMN		
L3931	RB		WHFO NONTORSION JOINT PREFAB	CMN	IOC	
L3931	NU		WHFO NONTORSION JOINT PREFAB	CMN		
L3933	RB		FO W/O JOINTS CF	CMN	IOC	
L3933	NU		FO W/O JOINTS CF	CMN		
L3935	RB		FO NONTORSION JOINT CF	CMN		
L3935	NU		FO NONTORSION JOINT CF	CMN		
L3956	NU		ADDITION OF JOINT TO UPPER EXTREMITY ORTHOSIS, ANYMATERIAL; PER JOINT	CMN	IOC	
L3960	RB		SEWHO, ABDUCTION POSITIONING, AIRPLANE DESIGN	CMN	IOC	
L3960	NU		SEWHO, ABDUCTION POSITIONING, AIRPLANE DESIGN,PREFABRICATED IN	CMN		
L3961	RB		SEWHO CAP DESIGN W/O JNTS CF	CMN	IOC	
L3961	NU		SEWHO CAP DESIGN W/O JNTS CF	CMN		
L3967	RB		SEWHO AIRPLANE W/O JNTS CF	CMN	IOC	
L3967	NU		SEWHO AIRPLANE W/O JNTS CF	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L3971	RB		SEWHO CAP DESIGN W/JNT(S) CF	CMN	IOC	
L3971	NU		SEWHO CAP DESIGN W/JNT(S) CF	CMN		
L3973	RB		SEWHO AIRPLANE W/JNT(S) CF	CMN	IOC	
L3973	NU		SEWHO AIRPLANE W/JNT(S) CF	CMN		
L3975	RB		SEWHFO CAP DESIGN W/O JNT CF	CMN	IOC	
L3975	NU		SEWHFO CAP DESIGN W/O JNT CF	CMN		
L3976	RB		SEWHFO AIRPLANE W/O JNTS CF	CMN	IOC	
L3976	NU		SEWHFO AIRPLANE W/O JNTS CF	CMN		
L3977	RB		SEWHFO CAP DESGN W/JNT(S) CF	CMN	IOC	
L3977	NU		SEWHFO CAP DESGN W/JNT(S) CF	CMN		
L3978	RB		SEWHFO AIRPLANE W/JNT(S) CF	CMN	IOC	
L3978	NU		SEWHFO AIRPLANE W/JNT(S) CF	CMN		
L3980	RB		UP EXT FX ORTHOS HUMERAL NOS	CMN	IOC	
L3980	NU		UP EXT FX ORTHOS HUMERAL NOS	CMN		
L3981	NU		UE FX ORTH SHOUL CAP FOREARM	CMN		
L3982	RB		UPPER EXTREMITY FRACTURE ORTHOSIS, RADIUS/ULNAR	CMN	IOC	
L3982	NU		UPPER EXTREMITY FRACTURE ORTHOSIS, RADIUS/ULNAR	CMN		
L3984	RB		UPPER EXTREMITY FRACTURE ORTHOSIS, WRIST	CMN	IOC	
L3984	NU		UPPER EXTREMITY FRACTURE ORTHOSIS, WRIST	CMN		
L3999	NU		UPPER LIMB ORTHOSIS, NOT OTHERWISE SPECIFIED	PA	IOC	
L4000	RB		REPLACE GIRDLE FOR MILWAUKEE ORTHOSIS	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L4002	NU		REPLACEMENT STRAP FOR AN ORTHOSIS, INCLUDES ALL COMPONENTS, AND LENGTH, ANY TYPE	CMN	IOC	
L4010	RB		REPLACE TRILATERAL SOCKET BRIM	CMN		
L4020	RB		REPLACE QUADRILATERAL SOCKET BRIM, MOLDED TO PATIENT MODEL	CMN		
L4030	RB		REPLACE QUADRILATERAL SOCKET BRIM, CUSTOM FITTED	CMN		
L4040	RB		REPLACE MOLDED THIGH LACER	CMN		
L4045	RB		REPLACE NON-MOLDED THIGH LACER, FOR CUSTOM FABRICATED ORTHOSIS	CMN		
L4050	RB		REPLACE MOLDED CALF LACER, FOR CUSTOM FABRICATED ORTHOSIS ONLY	CMN		
L4055	RB		REPLACE NON/MOLDED CALF LACER, FOR CUSTOM FABRICATED ORTHOSIS ONLY	CMN		
L4060	RB		REPLACE HIGH ROLL CUFF	CMN		
L4070	RB		REPLACE PROXIMAL AND DISTAL UPRIGHT FOR KAFO	CMN		
L4080	RB		REPLACE METAL BANDS KAFO, PROXIMAL THIGH	CMN		
L4090	RB		REPLACE METAL BANDS KAFO-AFO, CALF OR DISTAL THIGH	CMN		
L4100	RB		REPLACE LEATHER CUFF KAFO, PROXIMAL THIGH	CMN		
L4110	RB		REPLACE LEATHER CUFF KAFO-AFO, CALF OR DISTAL THIGH	CMN		
L4130	RB		REPLACE PRETIBIAL SHELL	CMN		
L4205	RB		REPAIR OF ORTHOTIC DEVICE. LABOR COMPONENT.	CMN		
L4210	RB		REPAIR OF ORTHOTIC DEVICE, REPAIR OR REPLACE MINOR PARTS	CMN	IOC	
L4360	NU		PNEUMA/VAC WALK BOOT PRE OTS	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L4361	NU		PNEUMA/VAC WALK BOOT PRE OTS	CMN		
L4386	NU		NON-PNEUM WALK BOOT PRE CST	CMN		
L4387	NU		NON-PNEUM WALK BOOT PRE OTS	CMN		
L4390	RB		REPLACE SOFT INTERFACE MATERIAL, MULTI-PODUS TYPE SPLINT	CMN	IOC	
L4392	RB		REPLACE SOFT INTERFACE MATERIAL, STATIC AFO	CMN	IOC	
L4394	RB		REPLACE SOFT INTERFACE MATERIAL, FOOT DROP SPLINT	CMN	IOC	
L4396	NU		STATIC OR DYNAMI AFO PRE CST	CMN		
L4397	NU		STATIC OR DYNAMI AFO PRE OTS	CMN		
L4398	NU		FOOT DROP SPLINT PRE OTS	CMN		
L4631	NU		AFO, WALK BOOT TYPE, CUS FAB	PA		
L5000	RB		PARTIAL FOOT, SHOE INSERT WITH LONGITUDINAL ARCH, TOE FILLER	CMN	IOC	
L5000	NU		PARTIAL FOOT, SHOE INSERT WITH LONGITUDINAL ARCH, TOE FILLER	CMN		
L5010	RB		PARTIAL FOOT, MOLDED SOCKET, ANKLE HEIGHT, WITH TOE FILLER	CMN	IOC	
L5010	NU		PARTIAL FOOT, MOLDED SOCKET, ANKLE HEIGHT, WITH TOE FILLER	CMN		
L5020	RB		PARTIAL FOOT, MOLDED SOCKET, TIBIAL TUBERCLE HEIGHT, WITH TOE FILLER	CMN	IOC	
L5020	NU		PARTIAL FOOT, MOLDED SOCKET, TIBIAL TUBERCLE HEIGHT, WITH TOE FILLER	CMN		
L5050	RB		ANKLE, SYMES, MOLDED SOCKET, SACH FOOT	CMN	IOC	

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L5050	NU		ANKLE, SYMES, MOLDED SOCKET, SACH FOOT	CMN		
L5060	RB		ANKLE, SYMES, METAL FRAME, MOLDED LEATHER SOCKET, ARTICULATED ANKLE/FOOT	CMN	IOC	
L5060	NU		ANKLE, SYMES, METAL FRAME, MOLDED LEATHER SOCKET, ARTICULATED ANKLE/FOOT	CMN		
L5100	RB		BELOW KNEE, MOLDED SOCKET, SHIN, SACH FOOT	CMN	IOC	
L5100	NU		BELOW KNEE, MOLDED SOCKET, SHIN, SACH FOOT	CMN		
L5105	RB		BELOW KNEE, PLASTIC SOCKET, JOINTS AND THIGH LACER, SACH FOOT	CMN	IOC	
L5105	NU		BELOW KNEE, PLASTIC SOCKET, JOINTS AND THIGH LACER, SACH FOOT	CMN		
L5150	RB		KNEE DISARTICULATION (OR THROUGH KNEE), MOLDED SOCKET, EXTERNAL KNEE JOINTS, SHIN, SACH FOOT	CMN	IOC	
L5150	NU		KNEE DISARTICULATION (OR THROUGH KNEE), MOLDED SOCKET, EXTERNAL KNEE JOINTS, SHIN, SACH FOOT	CMN		
L5160	RB		KNEE DISARTICULATION (OR THROUGH KNEE), MOLDED SOCKET, BENT KNEE CONFIGURATION, EXTERNAL KNEE JOINTS	CMN	IOC	
L5160	NU		KNEE DISARTICULATION (OR THROUGH KNEE), MOLDED SOCKET, BENT KNEE CONFIGURATION, EXTERNAL KNEE JOINTS	CMN		
L5200	RB		ABOVE KNEE, MOLDED SOCKET, SINGLE AXIS CONSTANT FRICTION KNEE, SHIN, SACH FOOT	CMN	IOC	
L5200	NU		ABOVE KNEE, MOLDED SOCKET, SINGLE AXIS CONSTANT FRICTION KNEE, SHIN, SACH FOOT	CMN		
L5210	RB		ABOVE KNEE, SHORT PROSTHESIS, NO KNEE JOINT (STUBBIES), WITH FOOT BLOCKS, NO ANKLE JOINTS, EACH	CMN	IOC	

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L5210	NU		ABOVE KNEE, SHORT PROSTHESIS, NO KNEE JOINT (STUBBIES), WITH FOOT BLOCKS, NO ANKLE JOINTS, EACH	CMN		
L5220	RB		ABOVE KNEE, SHORT PROSTHESIS, NO KNEE JOINT (STUBBIES), WITH ARTICULATED ANKLE/FOOT, DYNAMICALLY	CMN	IOC	
L5220	NU		ABOVE KNEE, SHORT PROSTHESIS, NO KNEE JOINT (STUBBIES), WITH ARTICULATED ANKLE/FOOT, DYNAMICALLY	CMN		
L5230	RB		ABOVE KNEE, FOR PROXIMAL FEMORAL FOCAL DEFICIENCY, CONSTANT FRICTION KNEE, SHIN, SACH FOOT	CMN	IOC	
L5230	NU		ABOVE KNEE, FOR PROXIMAL FEMORAL FOCAL DEFICIENCY, CONSTANT FRICTION KNEE, SHIN, SACH FOOT	CMN		
L5250	RB		HIP DISARTICULATION, CANADIAN TYPE; MOLDED SOCKET, HIP JOINT, SINGLE AXIS CONSTANT FRICTION KNEE, SH	CMN	IOC	
L5250	NU		HIP DISARTICULATION, CANADIAN TYPE; MOLDED SOCKET, HIP JOINT, SINGLE AXIS CONSTANT FRICTION KNEE, SH	CMN		
L5270	RB		HIP DISARTICULATION, TILT TABLE TYPE; MOLDED SOCKET, LOCKING HIP JOINT, SINGLE AXIS CONSTANT FRICTIO	CMN	IOC	
L5270	NU		HIP DISARTICULATION, TILT TABLE TYPE; MOLDED SOCKET, LOCKING HIP JOINT, SINGLE AXIS CONSTANT FRICTIO	CMN		
L5280	RB		HEMIPELVECTOMY, CANADIAN TYPE; MOLDED SOCKET, HIP JOINT, SINGLE AXIS CONSTANT FRICTION KNEE, SHIN, S	CMN	IOC	
L5280	NU		HEMIPELVECTOMY, CANADIAN TYPE; MOLDED SOCKET, HIP JOINT, SINGLE AXIS CONSTANT FRICTION KNEE, SHIN, S	CMN		
L5301	RB		BELOW KNEE, MOLDED SOCKET, SHIN, EACH FOOT, ENDOSKELETAL SYSTEM	CMN	IOC	
L5301	NU		BELOW KNEE, MOLDED SOCKET, SHIN, EACH FOOT, ENDOSKELETAL SYSTEM	CMN		
L5312	RB		KNEE DISART, SACH FT, ENDO	CMN	IOC	

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L5312	NU		KNEE DISART, SACH FT, ENDO	CMN		
L5321	RB		ABOVE KNEE, MOLDED SOCKET, OPEN END, SACH FOOT, ENDOSKELETAL SYSTEM, SINGLE AXIS KNEE	CMN	IOC	
L5321	NU		ABOVE KNEE, MOLDED SOCKET, OPEN END, SACH FOOT, ENDOSKELETAL SYSTEM, SINGLE AXIS KNEE	CMN		
L5331	RB		HIP DISARTICULATION, CANADIAN TYPE, MOLDED SOCKET, ENDOSKELETAL SYSTEM, HIP JOINT, SINGLE AXIS KNEE,	CMN	IOC	
L5331	NU		HIP DISARTICULATION, CANADIAN TYPE, MOLDED SOCKET, ENDOSKELETAL SYSTEM, HIP JOINT, SINGLE AXIS KNEE	CMN		
L5341	RB		HEMIPELVECTOMY, CANADIAN TYPE, MOLDED SOCKET, ENDOSKELETAL SYSTEM, HIP JOINT, SINGLE AXIS KNEE, SACH	CMN	IOC	
L5341	NU		HEMIPELVECTOMY, CANADIAN TYPE, MOLDED SOCKET, ENDOSKELETAL SYSTEM, HIP JOINT, SINGLE AXIS KNEE, SACH	CMN		
L5400	NU		IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF INITIAL RIGID DRESSING, INCLUDING FITTING	CMN		
L5410	NU		IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF INITIAL RIGID DRESSING, INCLUDING FITTING	CMN		
L5420	NU		IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF INITIAL RIGID DRESSING, INCLUDING FITTING	CMN		
L5430	NU		IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF INITIAL RIGID DRESSING, INCL FITTING	CMN		
L5450	NU		IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF NON- WEIGHT BEARING RIGID DRESSING, BELOW KNEE	CMN		
L5460	RB		IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF NON- WEIGHT BEARING RIGID DRESSING, ABOVE KNEE	CMN	IOC	
L5460	NU		IMMEDIATE POST SURGICAL OR EARLY FIT, APPLICATION OF NON-WEIGHT BEARING RIGID DRESSING, ABOVE KNEE	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L5500	RB		INITIAL, BELOW KNEE PTB TYPE SOCKET,NON-ALIGNABLE SYSTEM, PYLON, NO COVER, SACH FOOT, PLASTER SOCK	CMN	IOC	
L5500	NU		INITIAL, BELOW KNEE PTB TYPE SOCKET,NON-ALIGNABLE SYSTEM, PYLON, NO COVER, SACH FOOT, PLASTER SOCK	CMN		
L5505	RB		INITIAL, ABOVE KNEE-KNEE DISARTICULATION,ISCHIAL LEVEL SOCKET, NON-ALIGNABLE SYSTEM, PYLON, NO COVER, SAC	CMN	IOC	
L5505	NU		INITIAL, ABOVE KNEE-KNEE DISARTICULATION, ISCHIAL LEVEL SOCKET, NON-ALIGNABLE SYSTEM,PYLON, NO COVER, SAC	CMN		
L5510	RB		PREPARATORY, BELOW KNEE PTB TYPE SOCKET, NON-ALIGNABLE SYSTEM, PYLON, NO COVER, SACH FOOT, PLASTER SOCKET	CMN	IOC	
L5510	NU		PREPARATORY, BELOW KNEE PTB TYPE SOCKET, NON-ALIGNABLE SYSTEM, PYLON, NO COVER, SACH FOOT, PLASTER SOCKET	CMN		
L5520	RB		PREPARATORY, BELOW KNEE PTB TYPE SOCKET, NON-ALIGNABLE SYSTEM,PYLON,NO COVER,SACH FOOT THERMOPLASTIC	CMN	IOC	
L5520	NU		PREPARATORY, BELOW KNEE PTB TYPE SOCKET, NON-ALIGNALBE SYSTEM,PYLON, NO COVER, SACH FOOT, THERMOPLASTIC	CMN		
L5530	RB		PRE BK, PTB TYPE SOCKET, NON-ALIGNABLE SYSTEM, PYLON, NO COVER, SACH FOOT, THERMO OR EQUAL, MOLDED	CMN	IOC	
L5530	NU		PREP BK, PTB TYPE SOCKET, NON-ALIGNABLE SYSTEM, PYLON, NO COVER,S ACH FOOT, THERMO OR EQUAL, MOLDED	CMN		
L5535	RB		PREP, BK PTB TYPE SOCKET, NON-ALIGNABLE SYSTEM, PYLON, NO COVER, SACH FOOT, PREFABRICATED, ADJ OPEN END	CMN	IOC	
L5535	NU		PREP, BK PTB TYPE SOCKET, NON-ALIGNABLE SYSTEM, PYLON, NO COVER,SACH FOOT, PREFABRICATED, ADJ OPEN END	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L5540	RB		PREP, BK PTB TYPE SOCKET, NON-ALIGNABLE SYSTEM, PYLON, NO COVER, SACH FOOT, LAMINATED SOCKET, MOLDED	CMN	IOC	
L5540	NU		PREP, BK PTB TYPE SOCKET, NON-ALIGNABLE SYSTEM, PYLON, NO COVER, SACH FOOT, LAMINATED SOCKET, MOLDED	CMN		
L5560	RB		PREP, ABOVE KNEE-KNEE DISARTIC, ISCHIAL LEVEL SOCKET, NON-ALIGNABLE SYS,PYLON,NO COVER,SACH FOOT,PLASTIC	CMN	IOC	
L5560	NU		PREP, ABOVE KNEE-KNEE DISARTIC, ISCHIAL LEVEL SOCKET, NON-ALIGNABLE SYS,PYLON,NO COVER,SACH FOOT,PLASTIC	CMN		
L5570	RB		PREP, AK KNEE DISARTIC,ISCHIAL LEVEL SOCKET, NON-ALIGNABLE SYS, PYLON ,NO COVER, SACH FOOT, THERMOPLASTIC	CMN	IOC	
L5570	NU		PREP AK KNEE DISARTIC,ISCHIAL LEVEL SOCKET, NON-ALIGNABLE SYS, PYLON, NO COVER, SACH FOOT, THERMOPLASTIC	CMN		
L5580	RB		PREP, AK KNEE DISARTIC,ISCHIAL LEVEL SOCKET,NON-ALIGNABLE SYS, PYLON, NO COVER, SACH FOOT, THERMOPLASTIC	CMN	IOC	
L5580	NU		PREP AK KNEE DISARTIC, ISCHIAL LEVEL SOCKET, NON-ALIGNABLE SYS, PYLON, NO COVER, SACH FOOT, THERMOPLASTIC	CMN		
L5585	RB		PREP AK KNEE DISARTIC, ISCHIAL LEVEL SOCKET, NON-ALIGN SYS, PYLON, NO COVER, SACH FOOT,P REFABRICATED ADJ	CMN	IOC	
L5585	NU		PREP AK KNEE DISARTIC, ISCHIAL LEVEL SOCKET, NON-ALIGN SYS, PYLON, NO COVER, SACH FOOT, PREFABRICATED ADJ	CMN		
L5590	RB		PREP AK KNEE DISARTIC, ISCHIAL LEVEL SOCKET, NON-ALIGN SYS, PYLON, NO COVER,S ACH FOOT, LAMINATED SOCKET	CMN	IOC	
L5590	NU		PREP AK KNEE DISARTIC, ISCHIAL LEVEL SOCKET, NON-ALIGN SYS, PYLON, NO COVER, SACH FOOT, LAMINATED SOCKET	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L5595	RB		PREPARATORY, HIP DISARTICULATION-HEMIPELVECTOMY, PYLON, NO COVER, SACH FOOT, THERMOPLASTIC OR EQUAL	CMN	IOC	
L5595	NU		PREP, HIP DISARTIC-HEMIPELVECTOMY, PYLON, NO COVER, SACH FOOT, THERMOPLASTIC OR EQUAL, MOLDED TO PAT	CMN		
L5600	RB		PREPARATORY, HIP DISARTICULATION-HEMIPELVECTOMY, PYLON, NO COVER, SACH FOOT, LAMINATED SOCKET, MOLDED	CMN	IOC	
L5600	NU		PREPARATORY, HIP DISARTICULATION-HEMIPELVECTOMY, PYLON, NO COVER, SACH FOOT, LAMINATED SOCKET, MOLDED	CMN		
L5610	RB		ADDITION TO LOWER EXTREMITY, ENDOSKELETAL SYSTEM, ABOVE KNEE, HYDRACADENCE SYSTEM	CMN	IOC	
L5610	NU		ADDITION TO LOWER EXTREMITY, ENDOSKELETAL SYSTEM, ABOVE KNEE, HYDRACADENCE SYSTEM	CMN		
L5611	RB		ADD TO LOWER EXTREMITY, ENDOSKELETAL SYS, AK-KNEE DISARTIC, 4 BAR LINKAGE, WITH FRICTION SWING PHASE CO	CMN	IOC	
L5611	NU		ADD TO LOWER EXTREMITY, ENDOSKELETAL SYS, AK-KNEE DISARTIC, 4 BAR LINKAGE, WITH FRICTION SWING PHASE CO	CMN		
L5613	RB		ADD TO LOWER EXTREMITY, ENDOSKELETAL SYS, AK-KNEE DISARTIC, 4 BAR LINKAGE, WITH HYDRAULIC SWING PHASE	CMN	IOC	
L5613	NU		ADD TO LOWER EXTREMITY, ENDOSKELETAL SYS, ABOVE KNEE-KNEE DISARTICULATION, 4-BAR LINKAGE, WITH HYDRAULIC	CMN		
L5614	NU		ADD TO LOWER EXTREMITY, ENDOSKELETAL SYS, AK-KNEE DISARTIC, 4 BAR LINKAGE ,WITH PNEUMATIC SWING PHASE	CMN		
L5616	RB		ADD TO LOWER EXTREMITY, ENDOSKELETAL SYS, ABOVE KNEEUNIVERSAL MULTIPLEX SYS, FRICTION SWING PHASE CONTROL	CMN	IOC	
L5616	NU		ADD TO LOWER EXTREMITY, ENDOSKELETAL SYS, ABOVE KNEEUNIVERSAL MULTIPLEX SYS, FRICTION SWING PHASE CONTROL	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L5617	RB		ADDITION TO LOWER EXTREMITY, QUICK CHANGE SELF-ALIGNING UNIT, ABOVE OR BELOW KNEE, EACH	CMN	IOC	
L5617	NU		ADDITION TO LOWER EXTREMITY, QUICK CHANGE SELF-ALIGNING UNIT, ABOVE OR BELOW KNEE, EACH	CMN		
L5618	RB		ADDITION TO LOWER EXTREMITY, TEST SOCKET, SYMES	CMN	IOC	
L5618	NU		ADDITION TO LOWER EXTREMITY, TEST SOCKET, SYMES	CMN		
L5620	RB		ADDITION TO LOWER EXTREMITY, TEST SOCKET, BELOW KNEE	CMN	IOC	
L5620	NU		ADDITION TO LOWER EXTREMITY, TEST SOCKET, BELOW KNEE	CMN		
L5622	RB		ADDITION TO LOWER EXTREMITY, TEST SOCKET, KNEE DISARTICULATION	CMN	IOC	
L5622	NU		ADDITION TO LOWER EXTREMITY, TEST SOCKET, KNEE DISARTICULATION	CMN		
L5624	RB		ADDITION TO LOWER EXTREMITY, TEST SOCKET, ABOVE KNEE	CMN	IOC	
L5624	NU		ADDITION TO LOWER EXTREMITY, TEST SOCKET, ABOVE KNEE	CMN		
L5626	RB		ADDITION TO LOWER EXTREMITY, TEST SOCKET, HIP DISARTICULATION	CMN	IOC	
L5626	NU		ADDITION TO LOWER EXTREMITY, TEST SOCKET, HIP DISARTICULATION	CMN		
L5628	RB		ADDITION TO LOWER EXTREMITY, TEST SOCKET, HEMIPELVECTOMY	CMN	IOC	
L5628	NU		ADDITION TO LOWER EXTREMITY, TEST SOCKET, HEMIPELVECTOMY	CMN		
L5629	RB		ADDITION TO LOWER EXTREMITY, BELOW KNEE, ACRYLIC SOCKET	CMN	IOC	
L5629	NU		ADDITION TO LOWER EXTREMITY, BELOW KNEE, ACRYLIC SOCKET	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L5630	RB		ADDITION TO LOWER EXTREMITY, SYMES TYPE, EXPANDABLE WALL SOCKET	CMN	IOC	
L5630	NU		ADDITION TO LOWER EXTREMITY, SYMES TYPE, EXPANDABLE WALL SOCKET	CMN		
L5631	RB		ADDITION TO LOWER EXTREMITY, ABOVE KNEE OR KNEE DISARTICULATION, ACRYLIC SOCKET	CMN	IOC	
L5631	NU		ADDITION TO LOWER EXTREMITY, ABOVE KNEE OR KNEE DISARTICULATION, ACRYLIC SOCKET	CMN		
L5632	RB		ADDITION TO LOWER EXTREMITY, SYMES TYPE, SOCKET	CMN	IOC	
L5632	NU		ADDITION TO LOWER EXTREMITY, SYMES TYPE, PTB BRIM DESIGN SOCKET	CMN		
L5634	RB		ADDITION TO LOWER EXTREMITY, SYMES TYPE, POSTERIOR OPENING (CANADIAN) SOCKET	CMN	IOC	
L5634	NU		ADDITION TO LOWER EXTREMITY, SYMES TYPE, POSTERIOR OPENING (CANADIAN) SOCKET	CMN		
L5636	RB		ADDITION SOCKET	CMN	IOC	
L5636	NU		ADD TO LOWER EXTREMITY, SYMES TYPE MEDIAL OPENING SOCKET	CMN		
L5637	RB		ADDITION TO LOWER EXTREMITY, BELOW KNEE, TOTAL CONTACT	CMN	IOC	
L5637	NU		ADDITION TO LOWER EXTREMITY, BELOW KNEE, TOTAL CONTACT	CMN		
L5638	RB		ADDITION	CMN	IOC	
L5638	NU		ADDITION TO LOWER EXTREMITY, BELOW KNEE, TOTAL CONTACT LEATHER SOCKET	CMN		
L5639	RB		ADDITION TO LOWER EXTREMITY, BELOW KNEE, WOOD SOCKET	CMN	IOC	

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L5639	NU		ADDITION TO LOWER EXTREMITY, BELOW KNEE, TOTAL CONTACT WOOD SOCKET	CMN		
L5640	RB		ADDITION SOCKET	CMN	IOC	
L5640	NU		ADD KNEE DISARTICULATION, LEATHER SOCKET	CMN		
L5642	RB		ADDITION	CMN	IOC	
L5642	NU		ADD, ABOVE KNEE, LEATHER SOCKET	CMN		
L5643	RB		ADDITION EXTERNAL FRAME	CMN	IOC	
L5643	NU		ADDITION TO LOWER EXTREMITY,HIP DISARTICULATION, FLEXIBLE INNER SOCKET, EXTERNAL FRAME	CMN		
L5644	RB		ADDITION	CMN	IOC	
L5644	NU		ADDITION, TO LOWER EXTREMITY, ABOVE KNEE, WOOD SOCKET	CMN		
L5645	RB		ADDITION	CMN	IOC	
L5645	NU		ADD BELOW KNEE FLEXIBLE INNER SOCKET EXTERNAL FRAME	CMN		
L5646	RB		ADDITION	CMN	IOC	
L5646	NU		ADDITION, BELOW KNEE, AIR CUSHION SOCKET	CMN		
L5647	RB		ADDITION	CMN	IOC	
L5647	NU		ADDITION, BELOW KNEE SUCTION SOCKET	CMN		
L5648	RB		ADDITION	CMN	IOC	
L5648	NU		ADDITION, ABOVE KNEE AIR CUSHION SOCKET	CMN		
L5649	RB		ADDITION	CMN	IOC	
L5649	NU		ADDITION, ISCHIAL CONTAINMENT NARROW ML SOCKET CAT CAM SOCKET	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L5650	RB		ADDITIONS TO LOWER EXTREMITY, TOTAL CONTACT, ABOVE KNEE OR KNEE DISARTICULATION SOCKET	CMN	IOC	
L5650	NU		ADDITIONS TO LOWER EXTREMITY, TOTAL CONTACT, ABOVE KNEE OR KNEE DISARTICULATION SOCKET	CMN		
L5651	RB		ADDITION	CMN	IOC	
L5651	NU		ADDITION, TO LOWER EXTREMITY, ABOVE KNEE, FLEXIBLEINNER SOCKET, EXTERNAL FRAME	CMN		
L5652	RB		ADDITION OR KNEE DISARTICULATION SOCKET	CMN	IOC	
L5652	NU		ADD SUCTION SUSPENSION AK OR KNEE DISARTICULATION SOCKET	CMN		
L5653	RB		ADDITION WALL SOCKET	CMN	IOC	
L5653	NU		ADDITION KNEE DISARTICULATION, EXPANDABLE WALL SOCKET	CMN		
L5654	RB		ADDITION PELITE, ALIPLAST, PLASTAZOTE OR EQUAL)	CMN	IOC	
L5654	NU		ADDITION SYMES (KEMBLE, PELITE, ALIPLAST PLASTAZOTE OR EQUAL)	CMN		
L5655	RB		ADDITION (KEMBLO, PELITE, ALIPLAST, PLASTAZOTE OR EQUAL)	CMN	IOC	
L5655	NU		ADDITION TO LOWER EXTREMITY,SOCKET INSERT; BELOW KNEE, (KEMBLO, PELITE, ALIPLAST, PLASTAZOTE OR EQUAL)	CMN		
L5656	RB		ADDITION (KEMBLO, PELITE, ALIPLAST, PLASTAZOTE OR EQUAL)	CMN	IOC	
L5656	NU		ADD KNEE DISARTIC (KEMBLO, PELITE, ALIPLAST, PLASTAZOTE OR EQUAL)	CMN		
L5658	RB		ADDITION (KEMBLO, PELITE, ALIPLAST, PLASTAZOTE OR EQUAL)	CMN	IOC	
L5658	NU		ADD ABOVE KNEE (KEMBLO, PELITE, ALIPLAST, PLASTAZOTE OR EQUAL)	CMN		
L5661	RB		ADDITION	CMN	IOC	

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L5661	NU		ADDITION, MULTI-DUROMETIC, SYMES	CMN		
L5665	RB		ADDITION	CMN	IOC	
L5665	NU		ADDITION, MULTI-DUROMETER, BELOW KNEE	CMN		
L5666	RB		ADDITION	CMN	IOC	
L5666	NU		ADDITION, BELOW KNEE CUFF SUSPENSION	CMN		
L5668	RB		BK MOLDED DISTAL CUSHION	CMN	IOC	
L5668	NU		BK MOLDED DISTAL CUSHION	CMN		
L5670	RB		ADDITION SUSPENSION (PTS OR SIMILAR)	CMN	IOC	
L5670	NU		ADDITION BK MOLDED SUPRACONDYLAR SUSPENSION (PTS OR SIMILAR)	CMN		
L5671	RB		ADDITION TO LOWER EXTREMITY; BELOW KNEE/ABOVE KNEE SUSPENSION LO CKING MECHANISM (SHUTTLE, LANYARD)	CMN	IOC	
L5671	NU		ADDITION TO LOWER EXTREMITY; BELOW KNEE/ABOVE KNEE SUSPENSION LO CKING MECHANISM (SHUTTLE, LANYARD)	CMN		
L5672	RB		ADDITION BRIM SUSPENSION	CMN	IOC	
L5672	NU		ADDITION BELOW KNEE REMOVABLE MEDIAL BRIM SUSPENSION	CMN		
L5673	NU		SOCKET INSERT W LOCK MECH	CMN		
L5676	RB		ADDITIONS TO LOWER EXTREMITY, BELOW KNEE, KNEE JOINTS, SINGLE AXIS, PAIR	CMN	IOC	
L5676	NU		ADDITIONS TO LOWER EXTREMITY, BELOW KNEE, KNEE JOINTS, SINGLE AXIS, PAIR	CMN		
L5677	RB		ADDITIONS TO LOWER EXTREMITY, BELOW KNEE, KNEE JOINTS, POLYCENTRIC, PAIR	CMN	IOC	

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L5677	NU		ADDITIONS TO LOWER EXTREMITY, BELOW KNEE, KNEE JOINTS, POLYCENTRIC, PAIR	CMN		
L5678	RB		ADDITIONS TO LOWER EXTREMITY, BELOW KNEE, JOINT COVERS, PAIR	CMN	IOC	
L5678	NU		ADDITIONS TO LOWER EXTREMITY, BELOW KNEE, JOINT COVERS, PAIR	CMN		
L5679	NU		SOCKET INSERT W/O LOCK MECH	CMN		
L5680	RB		ADDITION MOLDED	CMN	IOC	
L5680	NU		ADDITION BELOW KNEE, THIGH LACER, NON-MOLDED	CMN		
L5681	NU		BELOW KNEE/ABOVE KNEE CUSTOM FAB SOCKET	CMN		
L5682	RB		ADDITION GLUTEAL/ISCHIAL, MOLDED	CMN	IOC	
L5682	NU		ADDITION TO LOWER EXTREMITY, BELOW KNEE, THIGH LACERGLUTEAL/ISCHIAL MOLDED	CMN		
L5683	NU		INITIAL SOCKET INSERT	CMN		
L5684	RB		ADDITION	CMN	IOC	
L5684	NU		ADDITION, BELOW KNEE, FORK STRAP	CMN		
L5685	NU		ADDITION TO BELOW KNEE PROSTHESIS, SUSPENSION/SEALING SLEEVE	CMN		
L5686	RB		ADDITION (EXTENSION CONTROL)	CMN	IOC	
L5686	NU		ADDITION BELOW KNEE, BACK CHECK EXTENSION CONTROL	CMN		
L5688	RB		ADDITION	CMN	IOC	
L5688	NU		ADDITION, BELOW KNEE WAIST BELT WEBBING	CMN		
L5690	RB		ADDITION AND LINED	CMN	IOC	
L5690	NU		ADDITION BELOW KNEE, WAIST BELT PADDED AND LINED	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L5692	RB		ADDITION LIGHT	CMN	IOC	
L5692	NU		ADDITION ABOVE KNEE PELVIC CONTROL BELT LIGHT	CMN		
L5694	RB		ADDITION PADDED AND LINED	CMN	IOC	
L5694	NU		ADDITION PELVIC CONTROL BELT PADDED AND LINED	CMN		
L5695	RB		ADDITION TO LOWER EXTREMITY, ABOVE KNEE, PELVIC CONTROL, SLEEVE SUSPENSION, NEOPRENE OR EQUAL, EACH	CMN	IOC	
L5695	NU		ADDITION TO LOWER EXTREMITY, ABOVE KNEE, PELVIC CONTROL, SLEEVE SUSPENSION, NEOPRENE OR EQUAL, EACH	CMN		
L5696	RB		ADDITION PELVIC JOINT	CMN	IOC	
L5696	NU		ADDITION ABOVE KNEE, OR KNEE DISARTICULATION PELVIC JOINT	CMN		
L5697	RB		ADDITION PELVIC BAND	CMN	IOC	
L5697	NU		ADDITION ABOVE KNEE OR KNEE DISARTIC PELVIC BAND	CMN		
L5698	RB		ADDITION SILESIAN BANDAGE	CMN	IOC	
L5698	NU		ADDITION ABOVE KNEE OR KNEE DISARTIC SILESIAN BANDAGE	CMN		
L5699	RB		ALL LOWER EXTREMITY PROSTHESES, SHOULDER HARNESS	CMN	IOC	
L5699	NU		ALL LOWER EXTREMITY PROSTHESES, SHOULDER HARNESS	CMN		
L5700	NU		REPLACEMENT, SOCKET, BELOW KNEE, MOLDED TO PATIENT MODEL	CMN		
L5701	NU		REPLACEMENT, SOCKET, ABOVE KNEE/KNEE DISARTICULATION, INCULDING ATTACHMENT PLATE, MOLDED TO PATIENT	CMN		
L5702	NU		REPLACEMENT, SOCKET, HIP DISARTICULATION, INCLUDING HIP JOINT, MOLDED TO PATIENT MODEL	CMN		
L5703	RB		SYMES ANKLE W/O (SACH) FOOT	CMN	IOC	

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L5703	NU		SYMES ANKLE W/O (SACH) FOOT	CMN		
L5704	NU		REPLACEMENT, CUSTOM SHAPED PROTECTIVE COVER, BELOW KNEE	CMN		
L5705	NU		REPLACEMENT, CUSTOM SHAPED PROTECTIVE COVER, ABOVE KNEE	CMN		
L5706	NU		REPLACEMENT, CUSTOM SHAPED PROTECTIVE COVER, KNEE DISARTICULATION	CMN		
L5707	NU		REPLACEMENT, CUSTOM SHAPED PROTECTIVE COVER, HIP DISARTICULATION	CMN		
L5710	RB		ADDITION	CMN	IOC	
L5710	NU		ADDITION, SINGLE AXIS, MANUAL LOCK	CMN		
L5711	RB		ADDITIONS EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, MANUAL LOCK, ULTRA-LIGHT MATERIAL	CMN	IOC	
L5711	NU		ADDITIONS EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, MANUAL LOCK, ULTRA-LIGHT MATERIAL	CMN		
L5712	RB		ADDITION, AND STANCE PHASE CONTROL (SAFETY KNEE)	CMN	IOC	
L5712	NU		ADDITION, SINGLE AXIS, FRICTION SWING AND STANCE PHASE CONTROL (SAFETY KNEE)	CMN		
L5714	RB		ADDITION, SWING PHASE CONTROL	CMN	IOC	
L5714	NU		ADDITION, SINGLE AXIS VARIABLE FRICTION SWING PHASE CONTROL	CMN		
L5716	RB		ADDITION, STANCE PHASE LOCK	CMN	IOC	
L5716	NU		ADDITION, POLYCENTRIC, MECHANICAL STANCE PHASE LOCK	CMN		
L5718	RB		ADDITION, AND STANCE PHASE CONTROL	CMN	IOC	

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L5718	NU		ADDITION, POLYCENTRIC, FRICTION SWING AND STANCE PHASE CONTROL	CMN		
L5722	RB		ADDITION, FRICTION STANCE PHASE CONTROL	CMN	IOC	
L5722	NU		ADDITION, SINGLE AXIS PNEUMATIC SWING FRICTION STANCE PHASE CONTROL	CMN		
L5724	RB		ADDITION, CONTROL	CMN	IOC	
L5724	NU		ADDITION, SINGLE AXIS FLUID SWING PHASE CONTROL	CMN		
L5726	RB		ADDITION, FLUID SWING PHASE CONTROL	CMN	IOC	
L5726	NU		ADDITION SINGLE AXIS EXTERNAL JOINTS FLUID SWING PHASE CONTROL	CMN		
L5728	RB		ADDITION, AND STANCE PHASE CONTROL	CMN	IOC	
L5728	NU		ADDITION SINGLE AXIS FLUID SWING AND STANCE PHASE CONTROL	CMN		
L5780	RB		ADDITION, PNEUMATIC SWING PHASE CONTROL	CMN	IOC	
L5780	NU		ADDITION SINGLE AXIS PNEUMATIC/HYDRAPNEUMATIC SWING PHASE CONTROL	CMN		
L5785	RB		ADDITION, EXOSKELETAL SYSTEM, BELOW KNEE, ULTRA-LIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL)	CMN	IOC	
L5785	NU		ADDITION, EXOSKELETAL SYSTEM, BELOW KNEE, ULTRA-LIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL)	CMN		
L5790	RB		ADDITION, EXOSKELETAL SYSTEM, ABOVE KNEE, ULTRA-LIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL)	CMN	IOC	
L5790	NU		ADDITION, EXOSKELETAL SYSTEM, ABOVE KNEE, ULTRA-LIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL)	CMN		
L5795	RB		ADDITION, EXOSKELETAL SYSTEM, HIP DISARTICULATION, ULTRA-LIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL)	CMN	IOC	

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L5795	NU		ADDITION, EXOSKELETAL SYSTEM, HIP DISARTICULATION, ULTRA-LIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL)	CMN		
L5810	RB		ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, MANUAL LOCK	CMN	IOC	
L5810	NU		ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, MANUAL LOCK	CMN		
L5811	RB		ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, MANUAL LOCK, ULTRA-LIGHT MATERIAL	CMN	IOC	
L5811	NU		ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, MANUAL LOCK, ULTRA-LIGHT MATERIAL	CMN		
L5812	RB		ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, FRICTION SWING AND STANCE PHASE CONTROL	CMN	IOC	
L5812	NU		ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, FRICTION SWING AND STANCE PHASE CONTROL	CMN		
L5814	NU		ADDITION,ENDOSKELETAL KNEE-SHIN SYSTEM, POLYCENTRICHYDRAULIC SWING PHASE CONTROL, MECHANICAL STANCE PHASE LOCK	CMN		
L5816	RB		ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, POLYCENTRIC, MECHANICAL STANCE PHASE LOCK	CMN	IOC	
L5816	NU		ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, POLYCENTRIC, MECHANICAL STANCE PHASE LOCK	CMN		
L5818	RB		ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, POLYCENTRIC, FRICTION SWING, AND STANCE PHASE CONTROL	CMN	IOC	
L5818	NU		ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, POLYCENTRIC, FRICTION SWING, AND STANCE PHASE CONTROL	CMN		
L5822	RB		ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, PNEUMATIC SWING, FRICTION STANCE PHASE CONTROL	CMN	IOC	

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L5822	NU		ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, PNEUMATIC SWING, FRICTION STANCE PHASE CONTROL	CMN		
L5824	RB		ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, FLUID SWING PHASE CONTROL	CMN	IOC	
L5824	NU		ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, FLUID SWING PHASE CONTROL	CMN		
L5826	NU		HYDRAULIC SWING PHASE CONTROL, WITH MINIATURE HIGH ACTIVITY FRAME	PA		
L5828	RB		ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, FLUID SWING AND STANCE PHASE CONTROL	CMN	IOC	
L5828	NU		ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, FLUID SWING AND STANCE PHASE CONTROL	CMN		
L5830	RB		ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, PNEUMATIC/SWING PHASE CONTROL	CMN	IOC	
L5830	NU		ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, PNEUMATIC/ SWING PHASE CONTROL	CMN		
L5840	NU		ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, 4-BAR LINKAGE OR MULTIAXIAL, PNEUMATIC SWING PHASE CONTROL	CMN		
L5845	RB		ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, STANCE FLEXION FEATURE, ADJUSTABLE	CMN	IOC	
L5845	NU		ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, STANCE FLEXION FEATURE, ADJUSTABLE	CMN		
L5848	NU		KNEE-SHIN SYS HYDRAUL STANCE	CMN		
L5850	RB		ADDITION, AK OR KNEE DISARTIC KNEE EXTENSION ASSIST	CMN	IOC	
L5850	NU		ADDITION, ENDOSKELETAL SYSTEM;ABOVE KNEE OR HIP DISARTICULATION, KNEE EXTENSION ASSIST	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L5855	NU		ADDITION, ENDOSKELETAL SYSTEM, HIP DISARTICULATION MECHANICAL HIP EXTENSION ASSIST	CMN		
L5856	NU		ADDITION TO ENDOSKELETAL KNEE-SHIN SYSTEM	CMN		
L5857	NU		ADDITION FOR ENDOSKELETAL KNEE-SHIN SYSTEM	CMN		
L5858	RB		STANCE PHASE ONLY	CMN	IOC	
L5858	NU		STANCE PHASE ONLY	CMN		
L5910	RB		ADDITION, BELOW KNEE ALIGNABLE SYSTEM	CMN	IOC	
L5910	NU		ADDITION, BELOW KNEE ALIGNABLE SYSTEM	CMN		
L5920	RB		ADDITION, ENDOSKELETAL SYSTEM, ABOVE KNEE OR HIP DISARTICULATION, ALIGNABLE SYSTEM	CMN	IOC	
L5920	NU		ADDITION, ENDOSKELETAL SYSTEM, ABOVE KNEE OR HIP DISARTICULATION, ALIGNABLE SYSTEM	CMN		
L5925	NU		ADDITION, ENDOSKELETAL SYSTEM, ABOVE KNEE, KNEE DISARTICULATION OR HIP DISARTICULATION, MANUAL	CMN		
L5930	RB		ADDITION, ENDOSKELETAL SYSTEM, HIGH ACTIVITY KNEE CONTROL FRAME	CMN	IOC	
L5930	NU		ADDITION, ENDOSKELETAL SYSTEM, HIGH ACTIVITY KNEE CONTROL FRAME	CMN		
L5940	RB		ADDITION, ENDOSKELETAL SYSTEM, BELOW KNEE, ULTRA-LIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL)	CMN	IOC	
L5940	NU		ADDITION, ENDOSKELETAL SYSTEM, BELOW KNEE, ULTRA-LIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL)	CMN		
L5950	RB		ABOVE KNEE, ULTRA-LIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL)	CMN		
L5950	NU		ABOVE KNEE, ULTRA-LIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL)	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L5960	RB		HIP DISARTICULATION, ULTRA LIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL)	CMN	IOC	
L5960	NU		HIP DISARTICULATION, ULTRA LIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL)	CMN		
L5961	NU		ENDO POLY HIP, PNEU/HYD/ROT	CMN	IOC	
L5962	NU		ADDITION, ENDOSKELETAL SYSTEM, BELOW KNEE, FLEXIBLE PROCTECTIVE OUTER SURFACE COVERING SYSTEM	CMN		
L5964	NU		ADDITION, ENDOSKELETAL SYSTEM, ABOVE KNEE, FLEXIBLE PROTECTIVE OUTER SURFACE COVERING SYSTEM	CMN		
L5966	NU		ADDITION, ENDOSKELETAL SYSTEM, HIP DISARTICULATION, FLEXIBLE PROTECTIVE OUTER SURFACE COVERING SYSTEM	CMN		
L5968	NU		ADDITION TO LOWER LIMB PROSTHESIS,MULTIAXIAL ANKLEWITH SWING PHASE ACTIVE DORSIFLEXION FEATURE	CMN		
L5970	RB		ALL LOWER EXTREMITY PROSTHESES, FOOT, EXTERNAL KEEL, SACH FOOT	CMN	IOC	
L5970	NU		ALL LOWER EXTREMITY PROSTHESES, FOOT, EXTERNAL KEEL, SACH FOOT	CMN		
L5971	RB		SACH FOOT, REPLACEMENT	CMN	IOC	
L5971	NU		SACH FOOT, REPLACEMENT	CMN		
L5972	RB		FLEXIBLE KEEL FOOT	CMN	IOC	
L5972	NU		FLEXIBLE KEEL FOOT	CMN		
L5974	RB		ALL LOWER EXTREMITY PROSTHESES, FOOT, SINGLE AXIS ANKLE/FOOT	CMN	IOC	
L5974	NU		FOOT, SINGLE AXIS ANKLE/FOOT	CMN		
L5975	NU		ALL L0WER EXTREMITY PROTHESIS; COMBINATION SINGLE AXIS ANKLE AND FLEXIBLE KEEL FOOT	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L5976	RB		ALL LOWER EXTREMITY PROSTHESES, ENERGY STORING FOOT (SEATTLE CARBON COPY II OR EQUAL)	CMN	IOC	
L5976	NU		ALL LOWER EXTREMITY PROSTHESES, ENERGY STORING FOOT (SEATTLE CARBON COPY II OR EQUAL)	CMN		
L5978	RB		ALL LOWER EXTREMITY PROSTHESES, FOOT, MULTIAXIAL ANKLE/FOOT	CMN	IOC	
L5978	NU		ALL LOWER EXTREMITY PROSTHESES, FOOT, MULTIAXIAL ANKLE/FOOT	CMN		
L5979	NU		ALL LOWER EXTREMITY PROSTHESES, MULTIAXIAL ANKLE/FOOT, DYNAMIC RESPONSE	CMN		
L5980	RB		ALL LOWER EXTREMITY PROSTHESES, FLEX FOOT SYSTEM	CMN	IOC	
L5980	NU		ALL LOWER EXTREMITY PROSTHESES, FLEX FOOT SYSTEM	CMN		
L5981	NU		ALL LOWER EXTREMITY PROSTHESES, FLEX-WALK SYSTEM OR EQUAL	CMN		
L5982	RB		ALL EXOSKELETAL LOWER EXTREMITY PROSTHESES, AXIAL ROTATION UNIT	CMN	IOC	
L5982	NU		ALL EXOSKELETAL LOWER EXTREMITY PROSTHESES, AXIAL ROTATION UNIT	CMN		
L5984	RB		ALL ENDOSKELETAL LOWER EXTREMITY PROSTHESES, AXIALROTATION UNIT	CMN	IOC	
L5984	NU		ALL ENDOSKELETAL LOWER EXTREMITY PROSTHESES, AXIAL ROTATION UNIT	CMN		
L5985	RB		ALL ENDOSKELETAL LOWER EXTREMITY PROSTHESES, DYNAMIC PROSTHETIC PYLON	CMN	IOC	
L5985	NU		ALL ENDOSKELETAL LOWER EXTREMITY PROSTHESES, DYNAMIC PROSTHETIC PYLON	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L5986	RB		ALL LOWER EXTREMITY PROSTHESES, MULTI-AXIAL ROTATION OR UNIT (MCP OR EQUAL)	CMN	IOC	
L5986	NU		ALL LOWER EXTREMITY PROSTHESES, MULTI-AXIAL ROTATION UNIT (MCP OR EQUAL)	CMN		
L5987	NU		ALL LOWER EXTREMITY PROSTHESIS, SHANK FOOT SYSTEM WITH VERTICAL LOADING PYLON	CMN		
L5988	NU		ADDITION TO LOWER LIMB PROSTHESIS, VERTICAL SHOCK REDUCING PYLON FEATURE	CMN		
L5990	NU		ADDITION TO LOWER EXTREMITY PROSTHESIS, USER ADJUSTABLE HEEL HEI GHT	CMN		
L5999	NU		LOWER EXTREMITY PROSTHESIS, NOT OTHERWISE SPECIFIED	PA	IOC	
L6000	RB		PART HAND THUMB REM	CMN	IOC	
L6000	NU		PART HAND THUMB REM	CMN		
L6010	RB		PART HAND LITTLE/RING	CMN	IOC	
L6010	NU		PART HAND LITTLE/RING	CMN		
L6020	RB		PART HAND NO FINGERS	CMN	IOC	
L6020	NU		PART HAND NO FINGERS	CMN		
L6050	RB		WRIST DISARTICULATION, MOLDED SOCKET, FLEXIBLE ELBOW HINGES, TRICEPS PAD	CMN	IOC	
L6050	NU		WRIST DISARTICULATION, MOLDED SOCKET, FLEXIBLE ELBOW HINGES, TRICEPS PAD	CMN		
L6055	RB		WRIST DISARTICULATION, MOLDED SOCKET WITH EXPANDABLE INTERFACE, FLEXIBLE ELBOW HINGES, TRICEPS PAD	CMN	IOC	
L6055	NU		WRIST DISARTICULATION, MOLDED SOCKET WITH EXPANDABLE INTERFACE, FLEXIBLE ELBOW HINGES, TRICEPS PAD	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L6100	RB		BELOW ELBOW, MOLDED SOCKET, FLEXIBLE ELBOW HINGE, TRICEPS PAD	CMN	IOC	
L6100	NU		BELOW ELBOW, MOLDED SOCKET, FLEXIBLE ELBOW HINGE, TRICEPS PAD	CMN		
L6110	RB		BELOW ELBOW, MOLDED SOCKET, (MUENSTER OR NORTHWESTERN SUS- PENSION TYPES)	CMN	IOC	
L6110	NU		BELOW ELBOW, MOLDED SOCKET, (MUENSTER OR NORTHWESTERN SUS- PENSION TYPES)	CMN		
L6120	RB		BELOW ELBOW, MOLDED DOUBLE WALL SPLIT SOCKET, STEP-UP HINGES, HALF CUFF	CMN	IOC	
L6120	NU		BELOW ELBOW, MOLDED DOUBLE WALL SPLIT SOCKET, STEP-UP HINGES, HALF CUFF	CMN		
L6130	RB		BELOW ELBOW, MOLDED DOUBLE WALL SPLIT SOCKET, STUMP ACTIVATED LOCKING HINGE, HALF CUFF	CMN	IOC	
L6130	NU		BELOW ELBOW, MOLDED DOUBLE WALL SPLIT SOCKET, STUMP ACTIVATED LOCKING HINGE, HALF CUFF	CMN		
L6200	RB		ELBOW DISARTICULATION, MOLDED SOCKET, OUTSIDE LOCKING HINGE, FOREARM	CMN	IOC	
L6200	NU		ELBOW DISARTICULATION, MOLDED SOCKET, OUTSIDE LOCKING HINGE, FOREARM	CMN		
L6205	RB		ELBOW DISARTICULATION, MOLDED SOCKET WITH EXPANDABLE INTERFACE, OUTSIDE LOCKING HINGES, FOREARM	CMN	IOC	
L6205	NU		ELBOW DISARTICULATION, MOLDED SOCKET WITH EXPANDABLE INTERFACE, OUTSIDE LOCKING HINGES, FOREARM	CMN		
L6250	RB		ABOVE ELBOW, MOLDED DOUBLE WALL SOCKET, INTERNAL LOCKING ELBOW, FOREARM	CMN	IOC	

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L6250	NU		ABOVE ELBOW, MOLDED DOUBLE WALL SOCKET, INTERNAL LOCKING ELBOW, FOREARM	CMN		
L6300	RB		SHOULDER DISARTICULATION, MOLDED SOCKET, SHOULDER BULKHEAD, HUMERAL SECTION, INTERNAL LOCKING ELBOW	CMN	IOC	
L6300	NU		SHOULDER DISARTICULATION, MOLDED SOCKET, SHOULDER BULKHEAD, HUMERAL SECTION, INTERNAL LOCKING ELBOW	CMN		
L6310	RB		SHOULDER DISARTICULATION, PASSIVE RESTORATION (COMPLETE PROS- THESIS)	CMN	IOC	
L6310	NU		SHOULDER DISARTICULATION, PASSIVE RESTORATION (COMPLETE PROS- THESIS)	CMN		
L6320	RB		SHOULDER DISARTICULATION, PASSIVE RESTORATION (SHOULDER CAP ONLY)	CMN	IOC	
L6320	NU		SHOULDER DISARTICULATION, PASSIVE RESTORATION (SHOULDER CAP ONLY)	CMN		
L6350	RB		INTERSCAPULAR THORACIC, MOLDED SOCKET, SHOULDER BULKHEAD, HUMERAL SECTION, INTERNAL LOCKING ELBOW	CMN	IOC	
L6350	NU		INTERSCAPULAR THORACIC, MOLDED SOCKET, SHOULDER BULKHEAD, HUMERAL SECTION, INTERNAL LOCKING ELBOW	CMN		
L6360	RB		INTERSCAPULAR THORACIC, PASSIVE RESTORATION (COMPLETE PROSTHESIS)	CMN	IOC	
L6360	NU		INTERSCAPULAR THORACIC, PASSIVE RESTORATION (COMPLETE PROSTHESIS)	CMN		
L6370	RB		INTERSCAPULAR THORACIC, PASSIVE RESTORATION (SHOULDER CAP ONLY)	CMN	IOC	
L6370	NU		INTERSCAPULAR THORACIC, PASSIVE RESTORATION (SHOULDER CAP ONLY)	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L6380	NU		IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF INITIAL RIGID DRESSING, INCLUDING FITTING	CMN		
L6382	NU		IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF INITIAL RIGID DRESSING INCLUDING FITTING	CMN		
L6384	NU		IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF INITIAL RIGID DRESSING INCLUDING FITTING	CMN		
L6386	NU		IMMEDIATE POST SURGICAL OR EARLY FITTING, EACH ADDITIONAL CAST CHANGE AND REALIGNMENT	CMN		
L6388	NU		IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF RIGID DRESSING ONLY	CMN		
L6400	RB		BELOW ELBOW, MOLDED SOCKET, ENDOSKELETAL SYSTEM, INCLUDING SOFT PROSTHETIC TISSUE SHAPING	CMN	IOC	
L6400	NU		BELOW ELBOW, MOLDED SOCKET, ENDOSKELETAL SYSTEM, INCLUDING SOFT PROSTHETIC TISSUE SHAPING	PA		
L6450	RB		ELBOW DISARTICULATION, MOLDED SOCKET, ENDOSKELETAL SYSTEM, INCLUDING SOFT PROSTHETIC TISSUE SHAPING	CMN	IOC	
L6450	NU		ELBOW DISARTICULATION, MOLDED SOCKET, ENDOSKELETAL SYSTEM, INCLUDING SOFT PROSTHETIC TISSUE SHAPING	PA		
L6500	RB		ABOVE ELBOW, MOLDED SOCKET, ENDOSKELETAL SYSTEM, INCLUDING SOFT PROSTHETIC TISSUE SHAPING	CMN	IOC	
L6500	NU		ABOVE ELBOW, MOLDED SOCKET, ENDOSKELETAL SYSTEM, INCLUDING SOFT PROSTHETIC TISSUE SHAPING	PA		
L6550	RB		SHOULDER DISARTICULATION, MOLDED SOCKET, ENDOSKELETAL SYSTEM, INCLUDING SOFT PROSTHETIC TISSUE SHAPING	CMN	IOC	
L6550	NU		SHOULDER DISARTICULATION, MOLDED SOCKET, ENDOSKELETAL SYSTEM, INCLUDING SOFT PROSTHETIC TISSUE SHAPING	PA		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L6570	RB		INTERSCAPULAR THORACIC, MOLDED SOCKET, ENDOSKELETAL SYSTEM, INCLUDING SOFT PROSTHETIC TISSUE SHAPING	CMN	IOC	
L6570	NU		INTERSCAPULAR THORACIC, MOLDED SOCKET, ENDOSKELETAL SYSTEM, INCLUDING SOFT PROSTHETIC TISSUE SHAPING	PA		
L6580	RB		PREPARATORY, WRIST DISARTICULATION OR BELOW ELBOW, SINGLE WALL PLASTIC SOCKET, FRICTION WRIST, FLEXIBLE	CMN	IOC	
L6580	NU		PREPARATORY, WRIST DISARTICULATION OR BELOW ELBOW, SINGLE WALL PLASTIC SOCKET, FRICTION WRIST, FLEXIBLE	CMN		
L6582	RB		PREPARATORY, WRIST DISARTICULATION OR BELOW ELBOW, SINGLE WALL SOCKET, FRICTION WRIST, FLEXIBLE ELBOW	CMN	IOC	
L6582	NU		PREPARATORY, WRIST DISARTICULATION OR BELOW ELBOW, SINGLE WALL SOCKET, FRICTION WRIST, FLEXIBLE ELBOW	CMN		
L6584	RB		PREPARATORY, ELBOW DISARTICULATION OR ABOVE ELBOW, SINGLE WALL PLASTIC SOCKET, FRICTION WRIST, LOCKING	CMN	IOC	
L6584	NU		PREPARATORY, ELBOW DISARTICULATION OR ABOVE ELBOW, SINGLE WALL PLASTIC SOCKET, FRICTION WRIST, LOCKING	CMN		
L6586	RB		PREPARATORY, ELBOW DISARTICULATION OR ABOVE ELBOW, SINGLE WALL SOCKET, FRICTION WRIST, LOCKING ELBOW	CMN	IOC	
L6586	NU		PREPARATORY, ELBOW DISARTICULATION OR ABOVE ELBOW, SINGLE WALL SOCKET, FRICTION WRIST, LOCKING ELBOW	CMN		
L6588	RB		PREPARATORY, SHOULDER DISARTICULATION OR INTERSCAPULAR THORACIC, SINGLE WALL PLASTIC SOCKET, SHOULDER	CMN	IOC	
L6588	NU		PREPARATORY, SHOULDER DISARTICULATION OR INTERSCAPULAR THORACIC, SINGLE WALL PLASTIC SOCKET, SHOULDER	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L6590	RB		PREPARATORY, SHOULDER DISARTICULATION OR INTERSCAPULAR THORACIC, SINGLE WALL SOCKET, SHOULDER JOINT	CMN	IOC	
L6590	NU		PREPARATORY, SHOULDER DISARTICULATION OR INTERSCAPULAR THORACIC, SINGLE WALL SOCKET, SHOULDER JOINT	CMN		
L6600	NU		UPPER EXTREMITY ADDITIONS, POLYCENTRIC HINGE, PAIR	CMN		
L6605	NU		UPPER EXTREMITY ADDITIONS, SINGLE PIVOT HINGE, PAIR	CMN		
L6610	NU		UPPER EXTREMITY ADDITIONS, FLEXIBLE METAL HINGE, PAIR	CMN		
L6615	NU		UPPER EXTREMITY ADDITION, DISCONNECT LOCKING WRIST UNIT	CMN		
L6616	NU		UPPER EXTREMITY ADDITION, ADDITIONAL DISCONNECT INSERT FOR LOCKING WRIST UNIT, EACH	CMN		
L6620	NU		UPPER EXTREMITY ADDITION, FLEXION FRICTION WRIST UNIT	CMN		
L6621	RB		FLEX/EXT WRIST W/WO FRICTION	CMN	IOC	
L6621	NU		FLEX/EXT WRIST W/WO FRICTION	CMN		
L6623	NU		UPPER EXTREMITY ADDITION, SPRING ASSISTED ROTATIONAL WRIST WITH LATCH RELEASE	CMN		
L6625	NU		UPPER EXTREMITY ADDITION, ROTATION WRIST UNIT WITH CABLE LOCK	CMN		
L6628	NU		UPPER EXTREMITY ADDITION, QUICK DISCONNECT HOOK ADAPTER OTTO BOCK OR EQUAL	CMN		
L6629	NU		UPPER EXTREMITY ADDITION, QUICK DISCONNECT LAMINATION COLLAR WITH COUPLING PIECE OTTO BOCK OR EQUAL	CMN		
L6630	NU		UPPER EXTREMITY ADDITION, STAINLESS STEEL, ANY WRIST	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L6632	NU		UPPER EXTREMITY ADDITION, LATEX SUSPENSION SLEEVE, EACH	CMN		
L6635	NU		UPPER EXTREMITY ADDITION, LIFT ASSIST FOR ELBOW	CMN		
L6637	NU		UPPER EXTREMITY ADDITIONS;NUDGE CONTROL ELBOW LOCK	CMN		
L6640	NU		UPPER EXTREMITY ADDITIONS, SHOULDER ABDUCTION JOINT, PAIR	CMN		
L6641	NU		UPPER EXTREMITY ADDITION, EXCURSION AMPLIFIER, PULLEY TYPE	CMN		
L6642	NU		UPPER EXTREMITY ADDITION, EXCURSION AMPLIFIER, LEVER TYPE	CMN		
L6645	NU		UPPER EXTREMITY ADDITION, SHOULDER FLEXION ABDUCTION JOINT, EACH	CMN		
L6650	NU		UPPER EXTREMITY ADDITION, SHOULDER UNIVERSAL JOINT, EACH	CMN		
L6655	NU		UPPER EXTREMITY ADDITION, STANDARD CONTROL CABLE, EXTRA	CMN		
L6660	NU		UPPER EXTREMITY ADDITION, HEAVY DUTY CONTROL	CMN		
L6665	NU		UPPER EXTREMITY ADDITION; TEFLON, OR EQUAL, CABLE LINING			
L6670	NU		UPPER EXTREMITY ADDITION, HOOK TO HAND CABLE ADAPTER	CMN		
L6672	NU		UPPER EXTREMITY ADDITION, HARNESS CHEST OR SHOULDER SADDLE TYPE	CMN		
L6675	NU		UPPER EXTREMITY ADDITION, HARNESS FIGURE OF 8 FOR SINGLE CONTROL	CMN		
L6676	NU		UPPER EXTREMITY ADDITION, HARNESS FIGURE OF 8 FOR DUAL CONTROL	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L6677	RB		UE TRIPLE CONTROL HARNESS	CMN	IOC	
L6677	NU		UE TRIPLE CONTROL HARNESS	CMN		
L6680	NU		UPPER EXTREMITY ADDITION, TEST SOCKET WRIST DISARTICULATION OR BELOW ELBOW	CMN		
L6682	NU		UPPER EXTREMITY ADDITION, TEST SOCKET ELBOW DISARTICULATION OR ABOVE ELBOW	CMN		
L6684	NU		UPPER EXTREMITY ADDITION, TEST SOCKET, SHOULDER DISARTIC OR INTERSCA PULAR THORACIC	CMN		
L6686	NU		UPPER EXTREMITY ADDITIONS; SUCTION SOCKET	CMN		
L6687	NU		UPPER EXTREMITY ADDITIONS; FRAME TYPE SOCKET, BELOW EL ELBOW OR WRIST DISARTICULATION	CMN		
L6688	NU		UPPER EXTREMITY ADDITIONS; FRAME TYPE SOCKET, ABOVE ELBOW OR ELBOW DISARTICULATION	CMN		
L6689	NU		UPPER EXTREMITY ADDITIONS; FRAME TYPE SOCKET, SHOULDER DISARTICULATION	CMN		
L6690	NU		UPPER EXTREMITY ADDITIONS; FRAME TYPE SOCKET INTERSCAPULAR THORACIC	CMN		
L6691	NU		UPPER EXTREMITY ADDITION, REMOVABLE INSERT, EACH	CMN		
L6692	NU		UPPER EXTREMITY ADDITIONS; SILICONE GEL INSERT OR EQUAL, EACH	CMN		
L6693	NU		UPPER EXTREMITY ADDITION, LOCKING ELBOW, FOREARM COUNTER BALANCE	CMN		
L6694	NU		ADDITION FOR BELOW ELBOW/ABOVE ELBOW, CUSTOM	PA		
L6695	NU		ADDITON FOR BELOW ELBOW/ABOVE ELBOW, CUSTOM	PA		
L6696	NU		ADDITION FOR BELOW ELBOW/ABOVE ELBOW, CUSTOM	PA		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L6697	NU		ADDITION FOR BELOW ELBOW/ABOVE ELBOW, CUSTOM	PA		
L6698	NU		ADDITION FOR BELOW ELBOW/ABOVE ELBOW, CUSTOM	PA		
L6706	NU		TERM DEV MECH HOOK VOL OPEN	CMN		
L6707	NU		TERMINAL DEVICE, HOOK, MECHANICAL, VOLUNTARY CLOSING, ANY MATERIAL, ANY SIZE, LINED OR UNLINED	CMN		
L6805	NU		ADDITION TO TERMINAL DEVICE, MODIFIER WRIST UNIT	CMN		
L6810	NU		ADDITION TO TERMINAL DEVICE, PRECISION PINCH DEVICE	CMN		
L6883	NU		REPLC SOCKT BELOW E/W DISA	CMN		
L6884	NU		REPLC SOCKT ABOVE ELBOW DISA	CMN		
L6885	NU		REPLC SOCKT SHLDR DIS/INTERC	CMN		
L7400	NU		ADD UE PROST BE/WD, ULTLITE	CMN		
L7401	NU		ADD UE PROST A/E ULTLITE MAT	CMN		
L7402	NU		ADD UE PROST S/D ULTLITE MAT	CMN		
L7403	NU		ADD UE PROST B/E ACRYLIC	CMN		
L7404	NU		ADD UE PROST A/E ACRYLIC	CMN		
L7405	NU		ADD UE PROST S/D ACRYLIC	CMN		
L7499	NU		UPPER EXTREMITY PROSTHESIS, NOT OTHERWISE SPECIFIED	PA	IOC	
L7510	RB		PROSTHETIC DEVICE REPAIR REP	CMN	IOC	
L7520	RB		REPAIR PROSTHESIS PER 15 MIN	CMN		
L7600	NU		PROSTHETIC DONNING SLEEVE	CMN	IOC	
L7700	NU		PROSTHETIC SOCK INSERT GASKET OR SEAL	CMN		
L7700	RB		PROSTHETIC SOCK INSERT GASKET OR SEAL	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L8000	NU		MASTECTOMY BRA	PC		3 PER 12 MONTHS
L8020	NU	LT	BREAST PROSTHESIS, MASTECTOMY FORM	PC		1 EVERY 6 MONTHS
L8020	NU	RT	BREAST PROSTHESIS, MASTECTOMY FORM	PC		1 EVERY 6 MONTHS
L8030	NU	LT	BREAST PROSTHES W/O ADHESIVE	PC		1 EVERY 24 MONTHS
L8030	NU	RT	BREAST PROSTHES W/O ADHESIVE	PC		1 EVERY 24 MONTHS
L8031	NU	LT	BREAST PROSTHESIS W ADHESIVE	PC		1 EVERY 24 MONTHS
L8031	NU	RT	BREAST PROSTHESIS W ADHESIVE	PC		1 EVERY 24 MONTHS
L8400	NU		PROSTHETIC SHEATH, BELOW KNEE, EACH	CMN		
L8410	NU		PROSTHETIC SHEATH, ABOVE KNEE, EACH	CMN		
L8415	NU		PROSTHETIC SHEATH, UPPER LIMB, EACH	CMN		
L8417	NU		PROSTHETIC SHEATH/SOCK, INCLUDING A GEL CUSHION LAYER, BELOW KNEE OR ABOVE KNEE, EACH	CMN		
L8420	NU		PROSTHETIC SOCK, MULTIPLE PLY; BELOW KNEE, EACH	CMN		
L8430	NU		PROSTHETIC SOCK, MULTIPLE PLY; ABOVE KNEE, EACH	CMN		
L8435	NU		PROSTHETIC SOCK MULTIPLE PLY; UPPER LIMB, EACH	CMN		
L8440	NU		PROSTHETIC SHRINKER, BELOW KNEE, EACH	CMN		
L8460	NU		PROSTHETIC SHRINKER, ABOVE KNEE, EACH	CMN		
L8465	NU		PROSTHETIC SHRINKER, UPPER LIMB, EACH	CMN		
L8470	NU		PROSTHETIC SOCK, SINGLE PLY, FITTING; BELOW KNEE, EACH	CMN		
L8480	NU		ABOVE KNEE, EACH	CMN		
L8485	NU		UPPER LIMB, EACH	CMN		

Procedure Code	Modifiers		Description	Reimbursement Guidelines		Limits Qty/Days and Comments
L8499	NU		UNLISTED PROCEDURE FOR MISCELLANEOUS PROSTHETIC SERVICES	PA	IOC	
L8500	RB		ARTIFICIAL LARYNX	CMN	IOC	
L8500	NU		ARTIFICIAL LARYNX	CMN		
L8501	NU		TRACHEOSTOMY SPEAKING VALVE	CMN		
L8505	NU		ARTIFICIAL LARYNX REPLACEMENT BATTER/ACCESSORY, ANY TYPE	CMN	IOC	
L8511	NU		INDWELLING TRACH INSERT	MNF		
L8512	NU		GEL CAP FOR TRACH VOICE PROST	MNF		
L8513	NU		TRACH PROS CLEANING DEVICE	MNF		
L8514	NU		REPL TRACH PUNCTURE DILATOR	MNF		
S8189	NU		TRACHEOSTOMY SUPPLY, NOC	CMN	IOC	
Z0160	RB		REPAIR OF EQUIPMENT, REPLACE OR REPAIR MINOR PARTS	CMN	MSRP	
Z0160	RB	SC	REPAIR OF EQUIPMENT, REPLACE OR REPAIR MINOR PARTS	CMN	MSRP	